

# Health Care Financing

## Grants and Contracts Report

Short-Term Evaluation of Medicaid: Selected Issues

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Health Care Financing Administration

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## Grants and Contracts Report

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*Short-Term Evaluation of Medicaid: Selected Issues* provides policy-relevant analyses based on information currently available from the Health Care Financing Administration's Medicaid data bases. This report focuses on the trends over time in Medicaid utilization and expenditures; the effect of eligibility decisions on programs costs; trends in utilization and expenditures for institutionalized persons; characteristics and costs of persons enrolled in both Medicaid and Medicare; and current State program changes.

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Short-Term Evaluation of  
Medicaid: Selected Issues

**U.S. Department of Health and Human Services**  
Health Care Financing Administration  
Office of Research and Demonstrations  
Baltimore, Maryland  
October 1984

This report was prepared for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Health Care Financing Administration (HCFA) under Contract No. HHS-100-82-0038 with Urban Systems Research and Engineering, Inc.

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The project team is indebted to many who participated in the study. Marilyn Rymer authored Chapter 3; Brian Burwell wrote Chapters 2 and 4; Denise Madigan authored Chapter 5; and all three contributed to Chapters 1 and 6. Editorial review was provided by John Heinberg and Gerald Adler. Barbara Mawn provided administrative support as project secretary.

The authors appreciate the cooperation shown by La Jolla Management Associates, SysteMetrics, and the Research Triangle Institute in sharing Medicaid data. In addition, credit should be given to Carol Iverson and Shelley Wetzel for their graphics support. Dave Baugh, Larry Corder, Al Dobson, Marian Gornick, Alma McMillan, Don Muse, Penelope Pine, Sherry Terrell, and Josh Weiner of HCFA, and Michele Adler of ASPE, served as members of a Work Group who met regularly to guide the project.



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## EXECUTIVE SUMMARY

This report, Short-Term Evaluation of Medicaid: Selected Issues, responds to an immediate need for information about the dynamics of the Medicaid program. The objective of the report is to synthesize recent research findings on several issues of immediate policy concern. It provides a summary of recent trends and program changes in Medicaid, as well as new findings in the areas of eligibility, institutionalized recipients, and dual enrollees for Medicaid and Medicare.

### RECENT MEDICAID PROGRAM EXPENDITURE GROWTH IS DRIVEN BY COSTS OF SERVING THE DISABLED AND AGED

- Medicaid Expenditures Have Been Growing at a 40% Faster Rate Than Either Federal or State Revenues

Between 1972 and 1982, the rate of growth in total Medicaid expenditures exceeded the rate of growth in Federal and State revenues by over 40%. Expenditures rose from \$6.3 billion in 1972 to \$29.9 billion in 1982, an Annual Compound Rate of Growth (ACRG) of 16.9 percent. In comparison, Federal revenues grew at an ACRG of 11.7 percent over the same period, and State revenues at an ACRG of 11.4 percent.

- Expenditure Increases Continue Despite Recent Decreases in Medicaid Enrollment

While rapid expenditure increases of the early 1970s can be attributed, at least in part, to growth in Medicaid enrollment, more recent expenditure increases cannot be. The Medicaid recipient population grew from 17.6 million persons in 1972 to 22.9 million persons in 1977, but since that time has decreased by about 1 million persons. In 1982, about 21.9 million persons (9.5% of the U.S. population) received medical services paid by Medicaid.



- The Aged Represent a Declining Proportion of Recipients, the Disabled an Increasing Proportion

Aged recipients comprise a declining proportion of the Medicaid population, despite the rapid growth in the elderly U.S. population in general. While the total elderly population grew by 28% between 1972 and 1982, the aged Medicaid population grew by only 1.5%. The decreasing percentage of elderly persons receiving Medicaid is largely attributable to the improved economic status of the elderly. The poverty rate among the elderly has declined dramatically in recent years.

In contrast, the Medicaid disabled population has grown substantially. The disabled population grew by 75% between 1972 and 1982, from 1.6 to 2.8 million recipients, and from 10% to 13% of the total Medicaid recipient population. This growth has been partly fueled by deinstitutionalization policies for the mentally disabled, which have increased the number of such persons eligible for SSI, and therefore Medicaid.

The AFDC-adult population has been growing more rapidly than the AFDC-child population, due to the shrinking size of AFDC families. Overall, however, the proportion of AFDC-related recipients to SSI-related recipients remained constant between 1972 and 1982. SSI-related recipients comprise about 28% of the population, AFDC-related recipients 66%, and others about 6%.

- SSI-related Recipients Account for An Increasing Proportion of All Medicaid Costs

Despite the fact that the ratio of SSI-related recipients to AFDC-related recipients has remained constant, total expenditures for the SSI-related population have been growing at a greater rate. Between 1973 and 1982, the proportion of total expenditures spent on the aged, blind and disabled increased from 62% to 72%. By 1982, the distribution of expenditures across the two major eligibility groups was almost opposite the distribution of recipients. The aged, blind, and disabled made up less than 30% of recipients, but accounted for over 70% of all costs. The AFDC-related population, on the other hand, made up 66% of the population, but accounted for only 26% of expenditures.



- Increases in Per Capita Costs for the Aged and the Disabled Account for Real Dollar Medicaid Expenditure Increases in Recent Years

It is the changing utilization and expenditure patterns of SSI-related recipients which have been driving real dollar expenditure increases in the Medicaid program in recent years. Expenditures for SSI-related recipients account for an increasing proportion of total costs due to more rapid increases in per capita costs. Increases in per capita costs for AFDC-related recipients (10.4% ACRG) approximated the rise in the medical care component of the Consumer Price Index (9.5% ACRG) over the ten year period. Per capita costs for SSI-related recipients, on the other hand, have increased at almost twice the inflation rate (17.9%).

#### OPTIONAL STATE ELIGIBILITY DECISIONS HAVE MAJOR EFFECTS ON MEDICAID EXPENDITURES AND ENROLLMENT

- Coverage of the Medically Needy Increases Medicaid Enrollment for a State by About 6% on Average, With Per Capita Costs of the Non-Institutionalized Medically Needy Running About 1.8 Times Greater Than Cash Recipients

In electing to cover the medically needy, States increase the eligibility rolls and incur additional Medicaid expenses. Medicaid program data for 1982 indicate that the medically needy accounted for 17.1% of all recipients and 36.4% of all expenditures in the 30 States with medically needy programs. However, these statistics generally overstate the effects of the medically needy option. Many medically needy recipients are persons who would be eligible for Medicaid even without a medically needy program. Most institutionalized medically needy recipients, in particular, would qualify as recipients in non-medically needy States, since every State has some provision for providing medical assistance to institutionalized persons not eligible for AFDC or SSI. If the distribution of recipients by maintenance assistance status in both medically needy and non-medically needy States is examined, the data show that States without medically needy programs report considerably higher proportions of categorically needy/no cash recipients than the medically needy States. This suggests that the net effect for an average State of selecting the medically needy option may be to increase total enrollment by about 6%, not 17%.

On the other hand, the impact of the medically needy option on program expenditures is significantly greater than on program enrollment. In medically needy States, the average cost per medically needy recipient was more than three times the average cost per categorically needy recipient. However, institutionalized recipients classified as medically needy (who are likely to be Medicaid-eligible even in the absence of the medically needy option) may substantially distort the real impact of this option. Therefore, expenditure analyses were conducted excluding institutionalized recipients. These analyses showed that the average cost per non-institutionalized medically needy recipient was only 1.8 times the average cost for the categorically needy.

- States Which Do Not Automatically Enroll SSI Recipients in Medicaid Show Lower Rates of Participation in Medicaid by SSI Recipients; However, Per Capita Costs for SSI Recipients in These States Are Greater

States have three options for enrolling aged, blind, and disabled SSI recipients in their Medicaid programs. First, States can elect to cover all SSI recipients automatically and not require them to make a special application for Medicaid ("1634" States). Second, States may elect to cover all SSI recipients, but only if they undergo a separate State determination procedure for Medicaid. Finally, States can choose the 209(b) option, which permits them to impose eligibility criteria more restrictive than those of SSI. Of these three options, the "1634" option is considered the least stringent, the 209(b) option the most restrictive, with the State determination option lying somewhere in between.

Analysis of recipient data confirms this hierarchy. The 209(b) option appears to reduce Medicaid recipient rates of aged SSI recipients by about 20%, in comparison to States employing the 1634 and State determination options. For disabled SSI recipients, there is an even greater effect. The 209(b) option appears to reduce Medicaid enrollment of disabled cash recipients by about 30% in comparison to 1634 States, and the State determination option lowers enrollment by about 15%. However, Medicaid per capita costs reflect a reverse hierarchy, in which 209(b) States show the highest per capita costs for SSI cash recipients, and 1634 States the lowest. Thus, it appears that while the State determination and 209(b) options do reduce Medicaid program enrollment, that the principal effect may be to screen out marginal users of medical services.

- Coverage of "Ribicoff Children" by States Expands the Medicaid Recipient Population by About 4%. The Per Capita Costs are 1.5 to 2 Times Greater Than the Cost of Serving AFDC Children

Another eligibility decision available to States includes whether or not to provide coverage of various populations which do not meet categorical criteria. One of the largest optional groups is all children in low-income families which are not AFDC-related (Ribicoff kids) -- a group covered by 29 States in 1982.

The impacts of covering this group must be inferred from indirect data sources, since there are no distinct reporting categories for them on HCFA reporting forms. The analysis estimated that coverage of Ribicoff kids expands the Medicaid recipient population by about 4%, but that the costs of serving this population were about 1.5 to 2 times greater on a per capita basis than the cost of covering AFDC-related children. The higher per capita costs associated with this group suggests that only low-income children who are high users of medical services tend to participate in this program.

- States With Higher Payment Levels for AFDC and SSI Show Much Greater Coverage of the Poor, Especially for AFDC-Related Children

States indirectly affect the size of their Medicaid program populations by the payment levels they establish for determining eligibility in their AFDC and State SSI supplementation programs. These payment levels vary significantly, from \$90 to \$508 per month for a family of two for AFDC cash assistance, and from \$297 (no State supplement) to \$815 per month for an aged couple for SSI State supplementation programs in 1982. Analyses showed that States with higher payment levels have larger Medicaid recipient populations than States with lower income levels for both SSI and AFDC. The effect was particularly pronounced in the coverage of poor children. The 10 States with highest AFDC payment levels had AFDC-child recipient populations averaging 116% of the total number of poor children in those States, compared to only 38% coverage for the 10 States with the lowest AFDC income levels.



- States With the Most Liberal Eligibility Policies Cover More of the Poor in Their Medicaid Programs. Their Per Capita Costs, However, Are Not Greater Than the Per Capita Costs of the States With the Most Restrictive Eligibility Policies

In addition to examining the effects of individual eligibility decisions, the study also examined State eligibiity policies on a broader level. To conduct this analysis, States were grouped in a six-tier classification scheme according to the comprehensiveness of their eligibility-related decisions. The results of this analysis generally confirmed the ordering of the classification scheme, but primarily at the extremes. The seven States with the most liberal eligibility policies accounted for only 30% of the U.S. poverty population but 47% of the total Medicaid population. In contrast, the thirteen States with the most restrictive eligibility policies accounted for 32% of the U.S. poverty population but only 21% of the total Medicaid population. When the classification scheme was applied to average per capita costs, however, it was not successful in rank-ordering States. States with the most restrictive eligibility criteria had about the same per capita costs as the most liberal States.

- Newly-Available Person-Based Medicaid Data From Two States (Michigan and New York) Show Several Important Results

- Many Medicaid Enrollees Do Not Use Medicaid Services. Approximately 20% of all enrollees in New York and Michigan did not use any Medicaid services in 1981.
- Length of Enrollment in Medicaid Varied Considerably Among Eligibility Groups. Disabled and aged enrollees show longer average enrollment periods than AFDC-related enrollees. The medically needy are not enrolled for as long as the cash assistance groups.
- When Length of Enrollment Is Taken Into Consideration, the Differences in Per Capita Costs Between Cash and Non/Cash Groups Are Larger. When measured in person-years of enrollment, the average medically needy enrollee cost \$4,682 in 1981 in Michigan compared to \$849 for cash assistance enrollees. For New York in the same year, the costs were \$6,478 for the average medically needy enrollee and \$1,088 for cash enrollees.

- A Small Proportion of Enrollees Account for Most Medicaid Costs. It is extremely misleading to talk about the "average" Medicaid recipient. In both New York and Michigan in 1981, 10% of enrollees accounted for 72%-75% of costs. The aged and the medically needy were over-represented among the high utilizer group in both States.

ACCELERATING COSTS FOR INSTITUTIONALIZED RECIPIENTS PLAY A KEY ROLE IN UNDERSTANDING MEDICAID EXPENDITURE GROWTH

- Nursing Home Recipients Comprise 7% of All Recipients, but Account for Almost Half of All Medicaid Costs

Nursing home recipients comprise 7.3% of the total Medicaid population, yet account for at least 43% of all expenditures. Since nursing home recipients incur Medicaid costs other than the cost for nursing homes (e.g., hospital, drug, and physician costs), it is commonly estimated that nursing home recipients account for almost half of all Medicaid expenditures.

In 1982, approximately 1.5 million persons had some portion of their nursing home bill paid for by Medicaid. Medicaid recipients comprise about half the total nursing home population, and in 1982, Medicaid paid just under half (48.7%) of the nation's total bill for nursing home care.

- Medicaid's Nursing Home Population Has Been Increasing Moderately

While the total Medicaid population declined moderately between 1975 and 1982, the Medicaid nursing home population increased by about 166,000 recipients, or 1.7% per year. Thus, nursing home recipients grew from 6.4% to 7.3% of all Medicaid recipients, and from 22% to 24% of all SSI-related recipients. The growth in the nursing home population is one factor in the large increase in per capita costs for SSI-related recipients. Of particular interest, however, is that for the most recently reported year (FY 1982), the Medicaid nursing home population declined by 125,000 recipients, or 7.8%.

- Although the Number of Aged Medicaid Nursing Home Recipients is Increasing, Institutionalization Rates Appear to be Declining

The aged Medicaid nursing home population as a proportion of the total U.S. elderly population has been declining moderately since 1976. In 1976, 4.6% of the all elderly persons were Medicaid nursing home recipients, compared to 4.2% in 1982.

- The Disabled Nursing Home Population Has Been Growing Rapidly

Disabled nursing home recipients on Medicaid grew by 33% between 1975 and 1982, more than three times the rate of growth of the aged Medicaid nursing home population. In 1975, the disabled accounted for 24% of all Medicaid expenditures for nursing home care; by 1982, this percentage had increased to 38%. Approximately a third of all disabled institutionalized recipients are mentally retarded persons being cared for in Intermediate Care Facilities for the Mentally Retarded (ICF-MRs); the remaining two-thirds are persons with a variety of disabilities being cared for in Intermediate Care Facilities (ICFs) and Skilled Nursing Facilities (SNFs).

- Medicaid Nursing Home Costs Are Growing Faster than the Cost of Other Medicaid Services

Total expenditures for nursing home care rose from \$4.7 billion in 1975 to just under \$13 billion in 1982, an ACRG of 15.7%. In comparison, total Medicaid expenditures grew at an ACRG of 13.5%. Consequently, nursing home expenditures have accounted for an increasing proportion of the Medicaid budget, from 38% of total expenditures in 1975 to 43% in 1982.

Percentage increases in average costs per nursing home recipient have been roughly equal to increases in average costs for all Medicaid recipients over this period. This means that over the entire period and for all types of care, nursing home expenditures have comprised an increasing proportion of total expenditures due almost entirely to increases in the number of institutionalized recipients relative to non-institutionalized recipients. More recently, this has not been the case. Between 1981 and 1982, the average cost per nursing home recipient increased by 16.8% compared to only about 7.9% for non-institutionalized recipients. These data tend to support a commonly-held hypothesis that with recent restrictions on nursing home bed supply, the Medicaid nursing home case mix is becoming increasingly impaired, resulting in increased average lengths of stay and higher costs per recipient.



- Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) Are a Major Factor in Increasing Nursing Home Costs

A major contributing factor in growing expenditures for nursing home care has been the rapid expansion of Intermediate Care Facilities for the Mentally Retarded (ICF-MRs). Since their addition to the Medicaid program in 1972, there has been both rapid development of new ICF-MRs and conversion of non-certified State institutions (previously 100% State funded) to ICF-MR standards. Since 1975, expenditures for ICF-MR care have increased at a remarkable ACRG of almost 40%, rising to \$3.6 billion in 1982. In 1975, ICF-MR expenditures accounted for just 8% of all nursing home expenditures; in 1982, they accounted for 28%. In fact, if payments for ICF-MR care were totally excluded from the Medicaid budget, nursing home payments for SNF and ICF care would have comprised the same proportion of all Medicaid expenditures in 1982 (34%) as in 1973. Put differently, the increasing proportion of Medicaid expenditures spent on nursing homes is entirely attributable to the growth in expenditures for ICF-MRs.

DUAL ENROLLEES FOR BOTH MEDICAID AND MEDICARE ARE A COSTLY MEDICAID POPULATION

Dual enrollees are individuals who are enrolled in both Medicare and Medicaid. Their eligibility for Medicare indicates that they are either aged or disabled. Their eligibility for Medicaid indicates that they also meet Medicaid financial eligibility criteria.

- An Estimated 15% of Medicaid Recipients Are Also Enrolled in the Medicare Program

The best available estimates indicate that dual enrollees numbered 3.3 million in 1978, accounting for roughly 12% of the Medicare Part B population and 15% of the entire Medicaid population. Aged dual enrollees numbered 2.8 million, and disabled dual enrollees numbered 0.5 million. As would be expected, the vast majority of aged Medicaid recipients are dual enrollees; however, there is much less overlap between the Medicare and Medicaid disabled populations. Only about 20% of the approximately 2.6 million disabled persons receiving Medicaid were also enrolled in the Medicare program.

- Aged Dual Enrollees Are Older and in Poorer Health Than Other Aged Persons in the Medicare Program

As a group, the aged dual enrollee population is older, with disproportionately more women and minorities, than the rest of the Medicare population. Not surprisingly, aged dual enrollees are also in poorer health than Medicare-only enrollees. Age-adjusted death rates for aged dual enrollees were 53% higher than for aged Medicare-only enrollees. In addition, aged dual enrollees were much more likely to perceive their own health status as only fair to poor.

- Aged Dual Enrollees Also Cost the Medicare Program More Than the Medicare-Only Aged

Compared to Medicare-only aged beneficiaries, aged dual enrollees were far more frequent and costly users of health care. After adjusting for age, Medicare reimbursements for aged dual enrollees averaged 50% higher than for aged Medicare-only enrollees.

- Total Health Care Costs for Aged Dual Enrollees Are Also Substantially Higher Than for the Medicare-Only Aged

The 1980 national NMCUES sample found that non-institutionalized aged dual enrollees incurred annual total health care costs of \$3,133 per capita, compared to \$1,818 for aged Medicare-only beneficiaries with other private coverage, and \$1,087 for aged Medicare-only beneficiaries without private coverage. For this non-institutionalized dual enrollee population, NMCUES found that Medicare paid for 57% of the total health care cost, Medicaid for 37%, other sources for the remaining 6%.

- Disabled Dual Enrollees Have Different Demographic Characteristics From Their Medicare-Only Counterparts

The vast majority of disabled dual enrollees are persons who were at one time employed and contributing to Social Security. Their Social Security entitlement makes them eligible for Medicare, while their relatively low incomes qualify them for Medicaid. Disabled dual enrollees tend to be younger, with more women and minorities, than other disabled Medicare enrollees.

- Disabled Dual Enrollees Cost the Medicare Program More Than the Medicare-Only Disabled

In 1978, average Medicare reimbursements for disabled dual enrollees were 27% higher than reimbursements for disabled Medicare-only enrollees, adjusted for age.

- State Medicaid Programs Electing to "Buy-In" Medicare Part B Coverage for Their Dual Enrollees Appear to Save Money as a Result

State Medicaid programs can elect to "buy-in" Medicare Part B coverage for some or all of their dual entitlements by paying the monthly premiums, coinsurance and deductibles for Part B services. In return, Medicare becomes first payer for those services covered by Medicare Part B, which includes physician, outpatient, home health, and other ambulatory care services.

In 1983, only 27 States purchased Medicare Part B coverage for all their Medicare-eligible Medicaid enrollees; 21 States purchased coverage for only cash assistance recipients, and the remaining 3 States had no buy-in arrangements at all. Analysis to estimate whether State Medicaid programs save money through "buy-in" agreements was conducted by calculating the difference between the costs of buying-in and costs of not buying-in. The results of this analysis showed that for every State for which reasonably complete cost data were available, buying-in generated savings. The average State saved \$367 per disabled buy-in and \$246 per aged buy-in. Furthermore, States which included the medically needy in their buy-in agreements had the highest average savings -- \$326 per aged buy-in and \$465 per disabled buy-in -- despite the fact that States pay more to buy-in for the medically needy than for the categorically needy.

#### STATES HAVE RESPONDED TO RECENT FEDERAL LEGISLATION ALLOWING THEM GREATER FLEXIBILITY IN MEDICAID PROGRAM DESIGN

Since 1980, the Medicaid program has undergone considerable legislative change. The three major pieces of legislation which have brought about these changes are:

- The Omnibus Reconciliation Act of 1980 (ORA)
- The Omnibus Budget Reconciliation Act of 1981 (OBRA)
- The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Two general themes of these Acts have been: (1) increased State flexibility in program design, and (2) cost containment. While the recency of these legislative changes precludes an evaluation of their impacts at this date, the study examined what responses States are making to these opportunities and what trends are suggested by these responses.



- Almost Every State Has Requested a Waiver from HCFA to Implement Home and Community-Based Services

Under Section 2176 of OBRA, States are allowed to apply to HCFA for a special waiver to finance non-medical home and community-based services through Medicaid. In order to receive HCFA approval for their waiver requests, States must demonstrate that total long-term care expenditures under the waiver program will be less than what total long-term care expenditures would have been without the program. State responses to the Section 2176 waiver program have exceeded all expectations. As of December 9, 1983, HCFA had received 105 waiver requests from 47 States, 62 of which had been approved, 6 disapproved, and 4 withdrawn. The remaining 33 requests were still pending. Of the 62 which have been approved, 29 waiver programs were targeted to aged/disabled persons, 28 to the mentally retarded, and 5 to the mentally ill. The most commonly applied for services are case management, adult day care, respite care, and habilitation.

- Several States Have Moved from Traditional Cost Based Systems of Inpatient Hospital Reimbursement to Alternative Methods Designed to Better Control Program Expenditures

To help contain hospital costs in the Medicaid program, OBRA granted States new flexibility in the establishment of inpatient hospital reimbursement methodologies. Under Section 2173, States are allowed to reimburse hospitals only for costs which were "reasonable and adequate to the the costs whch must be incurred by efficiently and economically operated facilities." As of early 1982, 17 States had departed from traditional cost-based methods of hospital reimbursement to alternate reimbursement methods. Of these 17, however, only 4 had done so under Section 2173 authority: Illinois, Kentucky, Missouri, and North Carolina. The other 13 States had changed reimbursement methods under HCFA demonstration authority.

- States Have Also Responded to OBRA Provisions Which Allow Them to Relax Medicaid Freedom-of-Choice Provisions

Prior to enactment of OBRA, Medicaid enrollees were generally free to seek medical care from any certified Medicaid provider. Section 2175 of OBRA relaxed the freedom-of-choice provision in several ways. As of June 15, 1983, 22 States had submitted a total of 47 waiver applications related to the freedom-of-choice provisions. Of these 47 applications, 25 were approved, 7 were pending, and 14 were either withdrawn or denied. Of the 25 approved waivers, the vast majority (19) involved primary care case management. Only 4 involved shared savings, and 7 restricted recipients to efficient and cost-effective care.

- Although Copayments Are Widely Used by State Medicaid Programs, Few States Have Responded to TEFRA Provisions Allowing Copayments to the Categorically Needy for Mandatory Services

In an attempt to increase cost-consciousness among Medicaid recipients, TEFRA allowed States to extend limited copayment requirements for certain services to the categorically needy. As of March 1983, 25 States had some form of copayments, copayments were applied most frequently to drug purchases (19 States), but also to a variety of other services, such as optometrist, chiropractor, and outpatient services. Most of these copayments were, however, in effect prior to the enactment of TEFRA. Only 3 States appear to have added copayments on mandatory services for the categorically needy.

- New Eligibility Options for Medicaid Have Received Varied Response at the State Level

Each of the three major pieces of Medicaid-related legislation enacted between 1980 and 1982 included changes in State options for eligibility policy. Some of these options have produced considerable response at the State level while others have not. Probably the greatest responses has been to the ORA change to allow States to prohibit transfer of assets in the 2 years prior to Medicaid application. This has been adopted by 30-35 States.

With regard to OBRA eligibility options, State response has been more variable. Of greatest interest, no State so far has adopted a limited medically needy program. Apparently the only States even considering it are States which currently do not have medically needy programs. About 7 States have set the maximum age for their coverage of Ribicoff children at less than 21 years of age. Thirty-one States have elected to cover pregnant women as an optional AFDC-related categorically needy group, while only 3 States have opted for the coverage of participants in subsidized employment.

Eleven States have responded to the TEFRA option allowing States to cover certain disabled children living at home who would previously have been eligible only in an institution (the so-called "Katie Beckett" children). No States have yet moved to exercise the TEFRA option of imposing liens on the homes of the institutionalized.

- States Have a Growing Interest in Alternative Family Responsibility Requirements for Medicaid

Although there have been no recent Federal changes in Medicaid law which alter the legal responsibilities of the families of Medicaid requests, there is growing interest at both the Federal and State levels to develop family responsibility requirements which address some of the deficiencies in existing Medicaid program policies. Policymakers recognize that some Medicaid provisions serve as disincentives to families to care for their elderly and disabled kin.

States have generally been considering two alternative approaches to Medicaid family responsibility provisions: (1) requiring family members of institutionalized Medicaid recipients to pay a portion of nursing home costs; and (2) providing financial incentives to families, either through tax deductions or direct payments, to care for their elderly kin.

So far, only one State (Idaho) has enacted a "family responsibility program" requiring family members of institutionalized recipients to contribute to the cost of care. Four States -- Idaho, Oregon, Iowa and Arizona -- are also experimenting with tax incentives for family caregiving. Outside the Medicaid program, a number of States have permitted direct payments to family members to provide care, under specified conditions. The primary risk of financial incentive programs is that instead of purchasing additional long-term care services, resources will be used to pay for care that would otherwise have been provided voluntarily without incentives.



## Chapter 1

### INTRODUCTION AND OVERVIEW

#### 1.1 Introduction

This report fills an immediate need for basic information and analyses regarding the Medicaid program. Its purpose is to assemble in coherent fashion the available evidence regarding significant program issues. It is an intermediate step in a series of studies conducted by the Office of Research and Demonstration (ORD) of the Health Care Financing Administration (HCFA) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The foundation for these studies is an evaluation plan for Medicaid which developed a list of evaluation topics and potential approaches.<sup>1</sup> The successor to the present study is an extensive three-year evaluation, which examines the consequences of program changes since the Omnibus Budget Reconciliation Act of 1981.

The present study is thus not a definitive evaluation, but rather an application of readily available information to those program issues which are validly and feasibly addressed in the short term. The focus of the report is in the following areas:

- The effect of State optional eligibility provisions on Medicaid enrollment and expenditures;
- The characteristics of the Medicaid nursing home population and nursing home expenditure patterns;
- The characteristics and expenditure patterns of persons who are enrolled in both Medicare and Medicaid (dual enrollees);

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<sup>1</sup>Evaluation Options for Medicaid, Urban Systems Research and Engineering, Inc. and SysMetrics, Inc., July 1982.

- State responses to recent legislative changes in the Medicaid program, most specifically the Omnibus Budget Reconciliation Act of 1981 (OBRA), and the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

Findings in these areas are presented in the context of recent trends in the Medicaid program.

## 1.2 Methodology

The overall objective of the study was to synthesize findings on the nine policy issues identified in the Medicaid evaluation plan. No original data collection and analysis was intended for the present report. Rather the purpose was to review and analyze data which were already available, though often not in published form.

The nine issues identified as evaluation priorities were the following:

1. Home and Community Based Care Waivers
2. Inpatient Hospital Reimbursement
3. Freedom of Choice Waivers
4. Copayments
5. Family Responsibility
6. Eligibility
7. Institutionalized Recipients
8. Dual Entitlees
9. Distribution of Medicaid Utilization and Expenditures

This report examines three of these issues in depth: Eligibility, Institutionalized Recipients, and Dual Entitlees. Since most of the remaining issues concern relatively recent changes to the Medicaid program, their discussion in this report is limited to how States have responded to the greater flexibility offered by recent legislation. The impact of these policy changes will be evaluated in-depth in the three-year Medicaid Program Evaluation study recently initiated by HCFA. The present report thus provides a "first-cut" look at these issues, using readily available data.

The major data sources reviewed for information on these issues are:

- 1) Annual Statistical Reporting Data (HCFA 2082). All Medicaid jurisdictions are required to submit annual aggregate statistical reports on Medicaid recipients, expenditures, and services provided on HCFA form 2082. This form is organized into 10 separate sections (A-J) which essentially require States to report participants, expenditures, and services provided in various cross-tabulations (by eligibility group, by cash assistance status, by age and sex, etc.) Sections A and B of HCFA form 2082 for the years 1975 through 1982 have recently been automated and can be accessed through the SAS programming language.

- 2) Tape-to-Tape Data. Under separate contract to SysMetrics, Inc., HCFA is sponsoring a project to develop automated, person-based uniform data files from State Medicaid Management Information Systems (MMIS). MMIS files from five States (New York, Michigan, California, Tennessee and Georgia) and three years (1980-1982) are being recoded into uniform research files containing complete eligibility, claims and provider data on State files. During the course of this study, Tape-to-Tape files for two States (New York and Michigan) and two years (1980 and 1981) were available. Analyses were limited to some 207 cross-tabulations of Tape-to-Tape for each State and year, (the Early Returns Tables). These cross-tabulations were selected by SysMetrics and were not chosen to be responsive to the needs of this study.
- 3) National Medical Care Utilization and Expenditure Survey (NMCUES) Data. The National Medical Care Utilization and Expenditure Survey (NMCUES) was a panel survey of 6000 randomly selected households nationwide and 4000 Medicaid households in four States conducted in 1980. Each household was interviewed a total of five times over the course of one year, three times in person and twice by phone. Interview data from Medicaid and Medicaid enrollees will be linked to administrative records maintained by States and HCFA. NMCUES data available to this study consisted of findings reported in approximately 10 preliminary research reports produced using the NMCUES data base.
- 4) Program Characteristics Data. Several HCFA research projects are attempting to collect and update uniform data on State Medicaid policies regarding eligibility, benefits, reimbursement and administration. When linked to other data sources, program characteristics data can be used to examine reasons for variation in Medicaid utilization and expenditures across States. State Medicaid Program Characteristics as of February 1982 were collected and reported by La Jolla Management Corporation. The Intergovernmental Health Policy Project (IHPP) and the National Governors Association (NGA) also collect and periodically report on recent and proposed changes in State Medicaid policies.
- 5) Medicaid Quality Control (MQC) System Data. The Medicaid Quality Control (MQC) System is a State and Federal program that systematically reviews a statistically reliable sample of Medicaid cases for the purpose of detecting errors in eligibility determination, claims payment, and misutilization of third party payors. A demonstration of



the feasibility of constructing a person-based data base from the MQC system was conducted, using the April to September 1980 HCFA re-review subsample in 32 States. This data base contains 10,000 cases and approximately 21,000 enrollees, and is presently being maintained by the Office of Evaluation and Technical Analysis within ASPE. Data requests were submitted to E&TA/ASPE as part of this contract, and special analysis runs were conducted exclusively for this study.

### 1.3 Limitations

By design, the analyses presented here were conducted under stringent time and resource constraints. The objective of the project was to begin, and not necessarily to conclude, an investigation of Medicaid evaluation issues. The most obvious limitation of this approach is that some analyses are not carried forward as far as they might have been with additional effort. Second, many of the data used were from available tabulations, rather than from special runs. Third, while new Medicaid data are continuously becoming available for analysis, the short-term evaluation could use (for the most part) only those data which were ready in the summer of 1983. This limitation most clearly affected the use of Tape-to-Tape data and MQC data. Both of these data sources when completely available will support much richer analysis for several of the issues covered in this report. Similarly, this report makes use of analyses conducted by the Office of Research as they stood in mid-1983, and does not incorporate more recent findings from new and ongoing studies.

The analyses presented in this report are further affected by the limitations of Medicaid data. For various reasons, the quality of Medicaid data over the years has been less than ideal, and many quality problems persist. In addition, the design of some of the data bases imposes inherent limitations, such as the fact that NMCUES includes only the non-institutionalized Medicaid population, the MQC sample is drawn from only 32 States, and 2082 data are in aggregate form. Specific limitations of each of the data bases are noted as appropriate in the presentation of data within each chapter of this report.

### 1.4 Organization of Report

The remainder of this chapter provides a detailed overview of findings. Chapters 2 through 6 supply their factual and analytic underpinnings. Chapter 2 highlights recent trends in the Medicaid program over the last ten years. Some underlying reasons for the dramatic rise in Medicaid expenditures are presented, as well as variations in the growth of expenditures across States. Chapters 3 through 5 then look at the Medicaid program from three different



perspectives. Chapter 3 examines how the decisions States make concerning eligibility provisions affect Medicaid enrollment and expenditures. Chapter 4 examines nursing home utilization and expenditures in the Medicaid program, the component with the fastest rising -- and most difficult to control -- costs. In Chapter 5, another high utilizer group is examined: aged and disabled beneficiaries who are dually enrolled in Medicaid and Medicare.

Chapter 6 summarizes recent legislative changes in the Medicaid program, particularly OBRA 1981 and TEFRA 1982, which allow States greater flexibility in the design of the program and which are intended to stem spiraling Medicaid expenditures. Six of the nine evaluation issues identified in the Evaluation Options for Medicaid report are discussed in this context -- home and community-based care, inpatient hospital reimbursement, freedom of choice waivers, copayments, family responsibility and eligibility.

### 1.5 Overview of Findings

#### Chapter 2: RECENT TRENDS IN THE MEDICAID PROGRAM

Between 1972 and 1982, the rate of growth in total Medicaid expenditures exceeded the rate of growth in Federal and State revenues by over 40%. Expenditures rose from \$6.3 billion in 1972 to \$29.9 billion in 1982, an Annual Compound Rate of Growth (ACRG) of 16.9 percent. In comparison, Federal revenues grew at an ACRG of 11.7 percent over the same period, and State revenues at an ACRG of 11.4 percent.

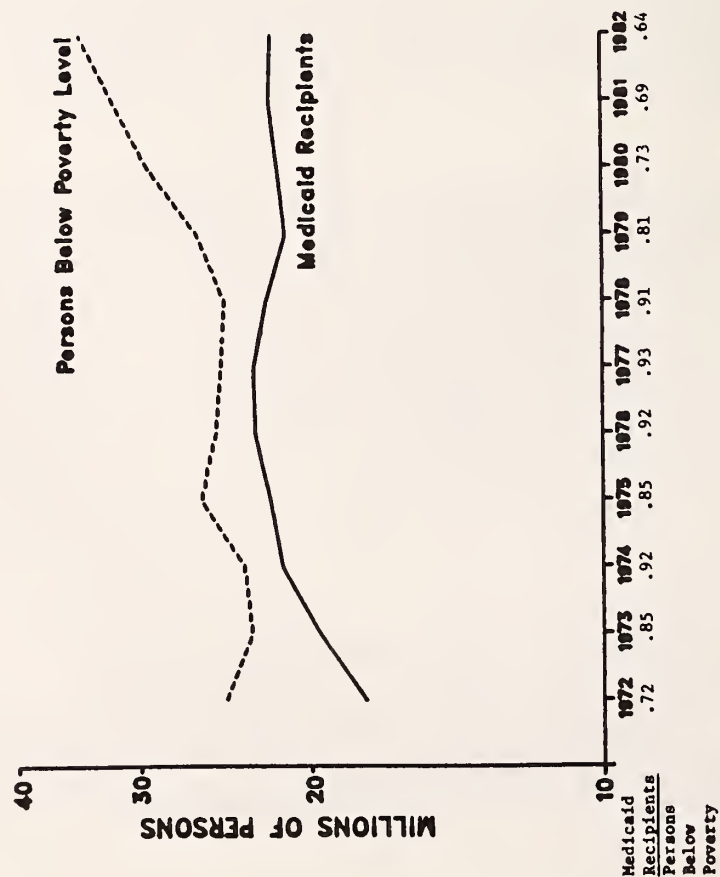
While rapid expenditure increases of the early 1970s can be attributed, at least in part, to growth in Medicaid enrollment, more recent expenditure increases cannot be. The Medicaid recipient population grew from 17.6 million persons in 1972 to 22.9 million persons in 1977, but since that time has decreased by about 1 million persons. In 1982, about 21.9 million persons (9.5% of the U.S. population) received medical services paid by Medicaid. This declining enrollment has led to a widening gap between the size of the Medicaid recipient population and the number of persons living below poverty level (Exhibit 1-1). However, many recent additions to the poverty population do not meet Medicaid categorical eligibility requirements, and there is continuing controversy over the adequacy of current poverty definitions, which are based solely on cash income.

#### Trends in Medicaid Enrollment by Eligibility Group

AFDC-related recipients comprised about two-thirds of the Medicaid population in 1982, while the aged, blind, disabled and others comprised the remaining one-third. The AFDC-adult population has been growing more rapidly than the AFDC-child population, due to

Exhibit 1-1

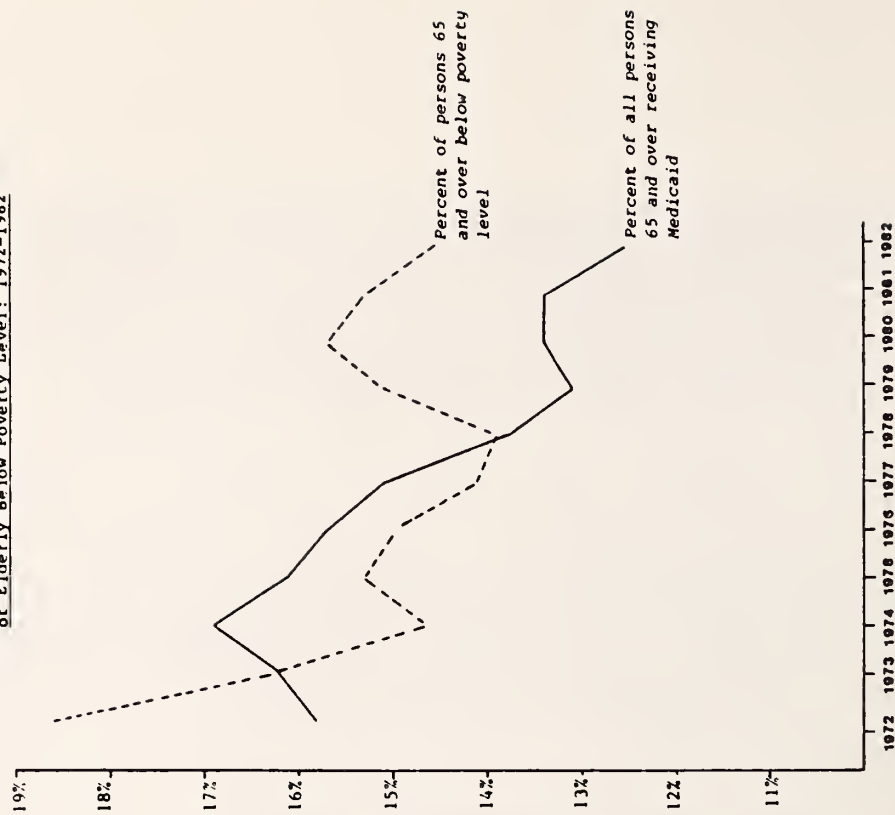
Enrollment Trends: Number of Medicaid Recipients and  
Number of Persons Below Poverty Level: 1972-1982



Sources: 2082 data and Statistical Abstract of the United States: 1982-1983.  
Recipient and poverty data are displayed on a logarithmic scale.

Exhibit 1-2

Percent of Elderly Persons on Medicaid and Percent  
of Elderly Below Poverty Level: 1972-1982



Sources: 2082 data and Social Security Bulletin: Annual  
Statistical Supplement, 1982.

the shrinking size of AFDC families. Within the SSI-related populations, the blind and disabled population has grown substantially, while aged recipients comprise a declining proportion of the Medicaid population. This may be somewhat surprising, given the rapid growth in the elderly U.S. population in general. While the total elderly population grew by 28% between 1972 and 1982, the aged Medicaid population grew by only 1.5%. The decreasing percentage of elderly persons receiving Medicaid is largely attributable to the improved economic status of the elderly. The poverty rate among the elderly has declined dramatically in recent years (Exhibit 1-2). In 1982, it dropped below the poverty rate for the non-elderly.

In contrast, there has been substantial growth in the SSI disabled population in recent years. This growth has been partly fueled by deinstitutionalization policies for the mentally disabled, which have increased the number of mentally disabled persons eligible for SSI, and therefore Medicaid.

Overall, however, there has been no change in the ratio of SSI-related recipients to AFDC-related recipients. Within the SSI-related groups the decline in aged recipients and the increase in disabled recipients have been offsetting. Consequently, the ratio of AFDC-related recipients to SSI-related recipients remained the same (2.5 to 1) between 1972 and 1982.

#### Trends in Medicaid Expenditures by Eligibility Group

Despite the fact that the ratio of AFDC-related recipients to SSI-related recipients has remained stable, total expenditures for SSI-related recipients have been growing at a greater rate than for AFDC-related recipients. Consequently, expenditures for SSI-related recipients grew from 62% to 72% of all Medicaid costs between 1973 and 1982. In 1982, the distribution of expenditures across the two major eligibility groups was almost the opposite the distribution of recipients (Exhibit 1-3). The aged, blind and disabled, who made up less than 30% of all recipients, accounted for 72% of all Medicaid costs. The AFDC population, on the other hand, made up 66% of the population, but accounted for only 26% of all expenditures.

#### Exhibit 1-3

##### Distribution of Recipients and Expenditures in the Medicaid Program, by Eligibility Group: 1982

<u>Eligibility Group</u>	<u>Recipients</u>	<u>Expenditures</u>
AFDC children	42%	12%
AFDC adults	24	14
Aged	15	36
Blind and Disabled	13	36
Other	6	2
	<u>100%</u>	<u>100%</u>



Expenditures for SSI-related recipients account for an increasing portion of costs due to more rapid increases in per capita costs for the aged, blind and disabled (Exhibit 1-4). Increases in the average cost per AFDC-related recipient (10.4% ACRG) have approximated the rise in the medical care component of the Consumer Price Index (9.5% ACRG) over the period. Average costs for SSI-related recipients, on the other hand, have increased at almost twice the inflation rate (17.9%). Thus, it is the changing utilization and expenditure patterns of the SSI-related groups which have been driving real dollar expenditure increases in the Medicaid program in recent years.

### Chapter 3: ELIGIBILITY

States have fairly wide discretion in deciding who is eligible for Medicaid. However, there has been little systematic analysis of the consequences of those decisions for State Medicaid programs. Therefore, this study examined available Medicaid program data in the context of State eligibility decision-making and its relationship to Medicaid enrollment and expenditure patterns. While there are a myriad of eligibility-related decisions, this report focused on the following key options:

- Whether or not to extend coverage to the "medically needy";
- Eligibility procedures for SSI-related recipients;
- Whether to extend coverage to the following optional populations:
  - all members in families with unemployed parents (AFDC-U);
  - all children in low-income families not eligible for AFDC (MA-21 or "Ribicoff kids"); and
- The establishment of payment and income levels for categorically needy and medically needy applicants.

#### Medically Needy Option

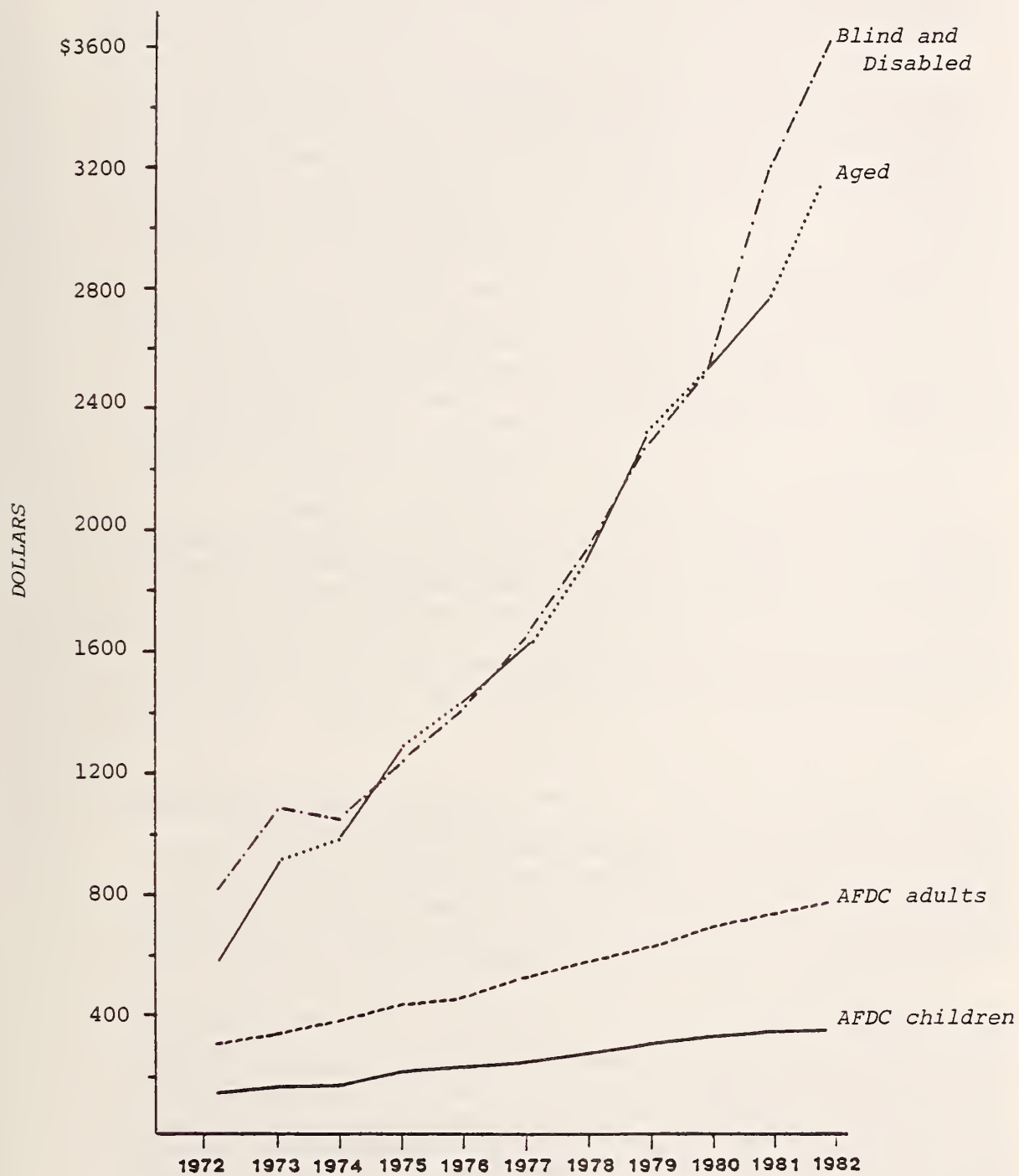
The medically needy option allows States to extend Medicaid coverage to categorically-related persons (i.e., persons who are aged, blind, disabled, or members of single-parent families) who are not financially eligible for SSI or AFDC cash assistance. The selection of the medically needy option implies a substantial commitment for a State because it essentially removes an income ceiling for those persons with heavy medical expenses and thus substantially increases the number of persons who are eligible for Medicaid. In 1982, 30 States had medically needy programs. The study analysis estimated the cost to an average State of offering Medicaid to medically needy persons.

Medicaid program data for 1982 indicate that the medically needy accounted for 17.1% of all recipients and 36.4% of all



Exhibit 1-4

Average Payment Per Recipient by Eligibility Category:  
1972-1982



Source: 2082 data

expenditures in medically needy States. However, there was considerable variation among States around these averages. These large variations make it difficult to generalize what effect the selection of the medically needy option is likely to have on State Medicaid expenditures.

Further analysis shows, however, that these aggregate statistics generally overstate the effects of the medically needy option. Many medically needy recipients who would be eligible for Medicaid even without a medically needy program. Most institutionalized medically needy recipients, in particular, would qualify as categorically needy/no cash recipients in non-medically needy States, since every State has some provision for providing medical assistance to institutionalized persons not on AFDC or SSI. If the distribution of recipients by maintenance assistance status in both medically needy and non-medically needy States is examined, the data show that States without medically needy programs report considerably higher proportions of categorically needy/no cash recipients than the medically needy States. This suggests that the net effect for an average State of selecting the medically needy option may be to increase total enrollment by about 6%, not 17%.

The impact of the medically needy option on program expenditures is significantly greater than on program enrollment. In medically needy States, the average cost per medically needy recipient was more than three times the average cost per categorically needy recipient. However, average costs for medically needy recipients were still less than for non-cash recipients in non-medically needy States, possibly related to the fact that many medically needy recipients contribute to the cost of care through "spend-down" provisions.

Since institutionalized recipients classified as medically needy substantially distort the real impact of the medically needy option, additional enrollment and expenditure analyses were conducted excluding institutionalized recipients. These analyses showed that the average cost per non-institutionalized medically needy recipient was only 1.8 times the average cost for the categorically needy (compared to over three times the average cost when the institutionalized are included).

Assuming that the medically needy option does not affect enrollment and expenditures for institutional care, it is estimated that the overall effect of the medically needy option is to expand overall program enrollment by about 6%, and that the average cost of serving these additional enrollees is 1.8 times the average cost of serving non-institutionalized categorically needy recipients. However, the large variations around these averages among medically needy States make it difficult to predict the enrollment and expenditure effects for any single State which may be considering adopting or dropping the medically needy option.

### Treatment of SSI Recipients

States have three options for enrolling aged, blind and disabled SSI recipients in their Medicaid programs. First, States can elect to cover all SSI recipients automatically and not require them to make a special application for Medicaid ("1634" States). Second, States may elect to cover all SSI recipients, but only if they undergo a separate State determination procedure for Medicaid. Finally, States can choose the 209(b) option, which permits them to impose eligibility criteria more restrictive than SSI. Of these three options, the "1634" option is considered the least stringent, the 209(b) option the most restrictive, with the State determination option lying somewhere in between.

Analysis of enrollment data confirms this hierarchy. The 209(b) option appears to reduce Medicaid recipient rates of aged categorically needy SSI recipients by about 20%, in comparison to States employing the 1634 and State determination options. For disabled SSI cash recipients, there is a greater effect. The 209(b) option appears to reduce Medicaid enrollment of disabled cash recipients by about 30% in comparison to 1634 States, and the State determination option by about 15%. However, per capita costs reflected a reverse hierarchy, in which 209(b) States showed the highest per capita costs for SSI cash recipients, and 1634 States the lowest. Thus, it appears that while the State determination and 209(b) options do reduce Medicaid program enrollment, the principal effect may be to screen out the marginal users of medical services.

However, there was considerable variation in both the recipient ratios and per capita costs among the States for each of the three SSI options. Therefore, these data have to be interpreted with caution.

### Optional Group Coverage

Other eligibility decisions available to States include whether or not to provide coverage of various populations which do not meet categorical criteria. Two of the largest optional groups are all children in low-income families which are not AFDC-related (Ribicoff kids) and families with unemployed parents (AFDC-U). In 1982, 29 States covered Ribicoff kids and 24 States covered families with unemployed parents.

The impacts of covering these two groups must be inferred from indirect data sources, since there are no distinct reporting categories for these groups on HCFA reporting forms. The analysis estimated that coverage of Ribicoff kids expands the Medicaid recipient population by about 4%, but that the cost of serving this



population was about 1.5 to 2 times greater on a per capita basis than the cost of covering AFDC-related children. One would expect comprehensive coverage of non-AFDC poor children to have greater effects on enrollment, but the higher per capita costs associated with this group again suggests that only low-income children who are high users of medical services tend to participate in the program.

AFDC program data were used to estimate the enrollment impacts of electing AFDC-U coverage. These data show that AFDC-U cash recipients comprise about 8% of the AFDC caseload in AFDC-U States. However, no data are available to indicate whether the per capita Medicaid costs of AFDC-U recipients differ from those experienced by the regular AFDC population.

#### Payment Levels

States indirectly affect the size of their Medicaid program populations by the payment levels they establish for their AFDC and State SSI supplementation programs. These income levels vary significantly, from \$89 to \$508 per month for a family of two for AFDC cash assistance, and from \$397 (no State supplement) to \$815 per month for an aged couple for SSI State supplementation programs in 1982. Analyses showed that States with higher payment levels have larger Medicaid recipient populations than States with lower payment levels for both SSI and AFDC. The effect was particularly pronounced in the coverage of poor children. The 10 States with highest AFDC payment levels had AFDC-child recipient populations which averaged 116% of the total number of poor children in those States, compared to only 38% coverage for the 10 States with the lowest AFDC payment levels.

#### An Eligibility Classification Scheme

In addition to examining the effects of individual eligibility decisions, the study examined State eligibility policies on a broader level. To conduct this analysis, States were grouped in a six-tier classification scheme according to the comprehensiveness of their eligibility-related decisions. Three criteria were used to group States in this scheme: first, whether or not the State had a medically needy program; second, whether the AFDC and SSI/SSP payment levels were above or below the median; and third, whether or not a State had elected the most "liberal" of the other eligibility options discussed previously.

The results of this analysis generally confirmed the ordering of the classification scheme, but primarily at the extremes (Exhibit 1-5). The seven States with the most liberal eligibility policies accounted for only 30% of the poverty population but 47% of the Medicaid population. In contrast, the thirteen States with the most restrictive eligibility policies accounted for 32% of the



Exhibit 1-5

Distribution of Overall Medicaid Recipients and U.S. Poverty  
Population by Eligibility Classification Scheme

	<u>% of Overall U.S. Medicaid Recipient Population - 1982</u>	<u>% of Overall U.S. Population Living Below Poverty Level - 1979*</u>
Tier 1	46.9%	29.5%
Tier 2	9.9%	9.5%
Tier 3	4.5%	4.7%
Tier 4	12.2%	17.1%
Tier 5	5.9%	6.3%
Tier 6	20.5%	31.7%

\* Does not sum to 100% because Arizona not included.

SOURCE: 2082 Data, 1982; Statistical Abstract of U.S. 1982-1983,  
Table 732, p. 443.

poverty population but only 21% of the Medicaid population. The analysis also suggested that AFDC and SSI payment levels and selection of optional coverage groups have greater impacts on program enrollment than the presence of a medically needy program. When the classification scheme was applied to average per capita costs, however, it was not successful in rank-ordering States on this criterion. No evidence, therefore, emerged that States with the most restrictive eligibility criteria are only screening out low utilizers, and are consequently serving a recipient population with higher per capita costs.

#### Person-Based Eligibility Data

Person-based eligibility data became available from the Tape-to-Tape project for two States (New York and Michigan) very late in the study. The potential for using this data base to conduct analyses relevant to eligibility policy-making is enormous. However, only preliminary analyses (the Early Returns Tables) were available for this study. Some highlights of these early results are:

- Enrollee/Recipient Ratios. The data showed that approximately 20% of all enrollees in New York and Michigan did not use any Medicaid services in 1981. This reciprocity rate varied by eligibility group and cash assistance status, with some differences in patterns between the two States.
- Length of Enrollment. The mean length of enrollment in Michigan was 9.3 months in 1981. For New York, the average was 8.8 months. For both States, there was greater turnover in the AFDC-related enrollment groups than in the SSI-related groups, and among the medically needy compared to cash assistance recipients.
- Expenditures and Utilization Patterns. When measured in person-years of enrollment, on average, medically needy enrollees cost \$4,682 per year in Michigan compared to \$849 for categorically needy enrollees receiving cash. For New York in the same year, the costs were \$6,478 on average for medically needy enrollees and \$1,088 for cash enrollees. In Michigan, medically needy enrollees had the highest user rates for inpatient hospital, long-term care and drug services, while cash enrollees were more likely to have used ambulatory care and dental services.
- High Cost Users. The analysis confirmed the commonly-held hypothesis that a minority of enrollees in the Medicaid program account for the vast majority of expenditures. In 1981 in Michigan, the 10% of recipients with the highest expenditures accounted for 72% of total expenditures. The

medically needy accounted for 38% of the high cost group, while they were only 8% of enrollees. In New York for the same year, 10% of recipients accounted for 75% of overall expenditures. The medically needy were 15% of enrollees but 52% of the high cost group. In both States, the aged were also disproportionately represented among high-cost users.

#### Chapter 4: INSTITUTIONALIZED RECIPIENTS

Though clearly not an intention of the original legislation, Medicaid has become the primary public payer for the nation's long-term care system. Many Medicaid policy-makers foresee that long-term care will be the most critical policy area in the coming decades, as the program confronts the inevitable demographics of an aging population.

#### The 1982 Medicaid Nursing Home Population

In 1982, approximately 1.5 million persons had some portion of their nursing home bill paid for by Medicaid. Medicaid recipients comprised about half the total nursing home population, and in 1982, Medicaid paid just under half (48.7%) of the nation's total bill for nursing home care.

Almost all institutionalized recipients are SSI-related: 73% are aged and 26% are disabled. In contrast, the aged and disabled make up less than one-fourth of the non-institutionalized Medicaid population. Within eligibility groups, 33% of all aged recipients and 14% of all disabled recipients received nursing home care at some point during 1982.

Overall, nursing home recipients comprised only 7.3% of the total Medicaid population, yet accounted for at least 43% of all expenditures. Since nursing home recipients incur Medicaid costs other than the cost for nursing homes (e.g., hospital, drug, and physician costs), it is commonly estimated that nursing home recipients account for over half of all Medicaid expenditures.

The distribution of Medicaid nursing home recipients and expenditures for 1982 by the type of nursing home care provided is displayed in Exhibit 1-6. Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) are by far the most costly form of nursing home care, averaging \$23,435 per recipient per year, compared to \$7,855 for recipients of Skilled Nursing Facilities and \$6,499 for recipients of Intermediate Care Facilities. Thus, ICF-MR recipients comprise 10% of all nursing home recipients, but account for 28% of all expenditures for nursing home care. Higher costs for ICF-MR recipients are due both to longer lengths of stay per recipient and to higher per diem costs.

Exhibit 1-6

Distribution of Nursing Home Recipients and Expenditures,  
and Average Per Capita Costs by Facility Type: 1982

<u>Facility Type</u>	<u>Recipients</u>		<u>Expenditures</u>		<u>Cost per</u>
	(n)	(%)	(\$000)	(%)	<u>Recipient</u> (\$)
Skilled Nursing Facilities (SNFs)	558,000	(38)	\$4,382,746	(34)	\$7,855
Intermediate Care Facilities (ICFs)	766,000	(52)	4,977,902	(38)	6,499
Intermediate Care Facilities for the Mentally Retarded (ICF-MRs)	<u>154,000</u>	<u>(10)</u>	<u>3,608,693</u>	<u>(28)</u>	<u>23,435</u>
Total	1,478,000	(100)	\$12,969,341	(100)	\$8,775

Recent Trends in Nursing Home Utilization and Expenditures:  
1975-1982

While the total Medicaid recipient population declined moderately between 1975 and 1982, the Medicaid nursing home population increased by about 160,000, or 1.7% per year. Thus, nursing home recipients grew from 6.4% to 7.3% of all Medicaid recipients over this period. Of particular interest, however, is that for the most recently reported year (FY 1982), the Medicaid nursing home population declined by 125,000, or 7.8%.

The aged Medicaid nursing home population as a proportion of the total U.S. elderly population appears to have been declining moderately since 1977. The data suggest that the proportion of all nursing home recipients on Medicaid may be declining. However, the Medicaid aged nursing home population is growing at a faster rate than the number of elderly persons in poverty (Exhibit 1-7).

Disabled nursing home recipients on Medicaid grew by 33% between 1975 and 1982, more than three times the rate of growth of the aged Medicaid nursing home population. The proportion of all institutionalized Medicaid recipients who were disabled thus increased from 22% to 26% over this period. Approximately a third of all disabled institutionalized recipients are mentally retarded persons being cared for in ICF-MRs; the remaining two-thirds are persons with a variety of disabilities being cared for in ICFs and SNFs.



Overall, the proportion of all SSI-related recipients receiving nursing home care rose from 22% in 1975 to about 24% in 1982. This increase in nursing home recipients partly explains why per capita costs for SSI-related recipients are rising faster than per capita costs for AFDC-related recipients, as discussed previously. However, per capita costs for non-institutionalized aged and disabled recipients have also been rising at a greater rate than per capita costs for the AFDC population.

Exhibit 1-7

Growth in the Medicaid Aged Nursing Home Population in  
Comparison to Other Aged Populations: 1975-1982

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	<u>Percent Change: 1975-1982</u>
All Aged Medicaid Recipients	- 7.5%
Aged Medicaid Nursing Home Home Recipients	+10.9%
Total U.S. Elderly Population	+19.6%
Total U.S. Elderly Population Below Poverty Level	+ 8.0%

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Nursing home expenditures have accounted for an increasing proportion of the Medicaid budget, from 38% of total expenditures in 1975 to 43% in 1982. Percentage increases in average costs per nursing home recipient have been roughly equal to increases in average costs for all Medicaid recipients over this period (Exhibit 1-8). This means that over the entire period and all types of care, nursing home expenditures have comprised an increasing proportion of total expenditures due almost entirely to increases in the number of institutionalized recipients relative to non-institutionalized recipients. More recently, this has not been the case. Between 1981 and 1982, the average cost per nursing home recipient increased by 16.8% compared to only about 7.9% for non-institutionalized recipients. These data tend to support a commonly-held hypothesis that with recent restrictions on nursing home bed supply, the Medicaid nursing home case mix is becoming increasingly impaired, resulting in increased average lengths of stay and higher costs per recipient.

A major contributing factor in growing expenditures for nursing home care has been the rapid expansion of Intermediate Care Facilities for the Mentally Retarded (ICF-MRs). Since their addition to the Medicaid program in 1972, there has been both rapid development of new ICF-MRs and conversion of non-certified State institutions (previously 100% State funded) to ICF-MR standards. Since 1975, expenditures for ICF-MR care have increased at a remarkable ACRG of almost 40%, rising to \$3.6 billion in 1982. In

1975, ICF-MR expenditures accounted for just 8% of all nursing home expenditures; in 1982, they accounted for 28%. In fact, if payments for ICF-MR care are totally excluded from the Medicaid budget, nursing home payments for SNF and ICF care would have comprised the same proportion of all Medicaid expenditures in 1982 (34%) as in 1973. Put differently, the increasing proportion of Medicaid expenditures spent on nursing homes is entirely attributable to the growth in expenditures for ICF-MRs.

Exhibit 1-8

Trends in Medicaid Nursing Home Recipients,  
Expenditures, and Costs per Recipient  
by Facility Type

	<u>SNFs</u>	<u>ICFs</u>	<u>ICF-MRs</u>	<u>Total Nursing Homes</u>	<u>Total Medicaid</u>
<u>Recipients</u>					
ACRG 1975-1982	-1.3%	+2.4%	+16.2%	+1.7%	-0.1%
<u>Expenditures</u>					
ACRG 1975-1982	+8.7	+15.0	+39.6	+15.7	+13.5
<u>Costs Per Recipient</u>					
ACRG 1975-1982	+10.1	+12.3	+20.2	+13.8	+13.6

Note: The medical component of the Consumer Price Index increased at an ACRG of 10.0% between 1975 and 1982.

Person-Based Data on Institutionalized Recipients

Aggregate statistics on costs per recipient understate real average costs per person since all recipients are counted equally whether they receive care for one day or the entire year. Person-based data are important since they can calculate costs per year of Medicaid enrollment rather than per recipient. Person-based data can also track expenditures for nursing home recipients over and above nursing home claims (e.g., physician costs, hospitalization costs, etc.). When these two modifications are made to Medicaid expenditure data for institutionalized recipients, costs increase substantially. In Michigan, when expenditures were adjusted to a person-year of enrollment basis, average costs for the

disabled increased 8%, and for the aged, 20%. In New York, which had shorter lengths of enrollment for its institutionalized population, average costs for the disabled increased 22%, and for the aged, 36%.

In both New York and Michigan, disabled recipients incurred higher additional service costs (other than nursing home care) than aged recipients. These additional service costs increased total average costs for disabled recipients in both States by 15.6%. Total average costs for aged institutionalized recipients rose between 6-8% when additional service costs were included. If these ratios are applied to the entire institutionalized Medicaid population, it is estimated that nursing home recipients account for 48% of all Medicaid costs (as opposed to 43% when only nursing home claims are counted).

#### Chapter 5: DUAL ENROLLEES

Dual enrollees are individuals who are enrolled in both Medicare and Medicaid. Their eligibility for Medicare indicates that they are either aged or disabled. Their eligibility for Medicaid indicates that they also meet Medicaid financial eligibility criteria.

Dual enrollees are of interest to policymakers because they form a link through which changes in one program may affect utilization and expenditures in the other. For example, one concern of Medicaid policy-makers is that the new Medicare hospital prospective payment system will put pressures on hospitals to discharge dual enrollees to nursing homes as soon as possible, which will lead to increased Medicaid costs. Policymakers are also interested in the total public costs of serving dual enrollees in both Medicare and Medicaid. State Medicaid policymakers, in particular, have a special interest in the utilization patterns of dual enrollees, since they have the option of "buying in" Medicare Supplementary Insurance (Part B) for many of their aged and disabled Medicaid enrollees.

#### The Dual Enrollee Population

Data on the total number of dual enrollees is hampered by the unavailability of linked Medicaid and Medicare data systems on the universe of dual enrollees. The best available estimates indicate that dual enrollees numbered 3.3 million in 1978, accounting for roughly 12% of the Medicare Part B population and 15% of the entire Medicaid population. Aged dual enrollees numbered 2.8 million, and disabled dual enrollees numbered 0.5 million. As would be expected, the vast majority of aged Medicaid recipients are dual enrollees; however, there is much less overlap between the Medicare and



Medicaid disabled populations. Only about 20% of the approximately 2.6 million disabled persons receiving Medicaid were also enrolled in the Medicare program.

#### Aged Dual Enrollees

In many ways, the characteristics of the aged dual enrollee population are similar to those of the elderly poor population. Thus, as a group, the aged dual enrollee population is older, with disproportionately more women and minorities, than the rest of the Medicare population. Aged dual enrollees are also in poorer health than Medicare-only enrollees. Age-adjusted death rates for aged dual enrollees were 53% higher than for Medicare-only enrollees, and aged dual enrollees were much more likely to perceive their own health status as only fair or poor.

Compared to Medicare-only aged beneficiaries, aged dual enrollees were more frequent and costly users of health care. After adjusting for age, Medicare reimbursements for aged dual enrollees averaged 50% higher than for aged Medicare-only enrollees.

The National Medical Care Utilization and Expenditure Survey (NMCUES) data base is currently unique in providing linked Medicaid and Medicare utilization data for non-institutionalized dual enrollees. The 1980 national NMCUES sample found that non-institutionalized aged dual enrollees incurred annual total health care costs of \$3,133 per capita, compared to \$1,818 for aged Medicare-only beneficiaries with other private coverage, and \$1,087 for aged Medicare-only beneficiaries without private coverage. Out-of-pocket expenditures for aged dual enrollees, however, were only \$233 per year, compared to \$352 for other Medicare beneficiaries with private coverage, and \$319 for Medicare beneficiaries without private coverage. For this non-institutionalized dual enrollee population, NMCUES found that Medicare paid for 57% of the total health care cost, Medicaid for 37%, other sources for the remaining 6%.

#### Disabled Dual Enrollees

The vast majority of disabled dual enrollees are persons who were at one time employed and contributing to Social Security. Their Social Security entitlement makes them eligible for Medicare, while their relatively low incomes qualify them for Medicaid. Disabled dual enrollees tend to be younger, with more women and minorities, than other disabled Medicare enrollees.

In 1978, average Medicare reimbursements for disabled dual enrollees were 27% higher than reimbursements for disabled Medicare-only enrollees, adjusted for age.



## State Buy-In Decisions

State Medicaid programs can elect to "buy-in" Medicare Part B coverage for some or all of their dual entitlements by paying the monthly premiums, coinsurance and deductibles for Part B services. In return, Medicare becomes first payer for those services covered by Medicare Part B, which includes physician, outpatient, home health, and other ambulatory care services. Regulations covering buy-in agreements are fairly complex, and vary for cash assistance and no cash Medicaid enrollees.

In 1983, only 27 States purchased Medicare Part B coverage for all their Medicare-eligible Medicaid enrollees; 21 States purchased coverage for only cash assistance recipients, and the remaining 3 States had no buy-in arrangements at all. An analysis to estimate whether State Medicaid programs save money through "buy-in" agreements was conducted by calculating the difference between the costs of buying-in and costs of not buying-in. Costs to States for premiums, coinsurance and deductibles for persons bought-in to Medicare were compared with Medicare expenditures for buy-ins under Part B. The analysis assumed that Medicaid programs would have had to incur costs equal to Medicare Part B reimbursements if they had not bought-in.

The results of this analysis showed that for every State for which reasonably complete cost data were available, buying-in generated savings. The average State saved \$367 per disabled buy-in and \$246 per aged buy-in. Furthermore, States which included the medically needy in their buy-in agreements had the highest average savings -- \$327 per aged buy-in and \$465 per disabled buy-in -- despite the fact that States pay more to buy-in for the medically needy than for the categorically needy/cash population.

## Chapter 6: CURRENT MEDICAID PROGRAM CHANGES

Since 1980, the Medicaid program has undergone considerable legislative change. The three major pieces of legislation which have brought about these changes are:

- The Omnibus Reconciliation Act of 1980 (ORA 1980)
- The Omnibus Budget Reconciliation Act of 1981 (OBRA 1981)
- The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

Two general themes of these Acts have been: (1) increased State flexibility in program design, and (2) cost containment. Interviews with policymakers showed interest in information on the impacts of these recent initiatives in the following five areas:

- Reducing institutional costs: home and community-based services waivers;

- Containing provider costs: changes in hospital reimbursement;
- Increasing cost consciousness and restricting enrollees to efficient providers: freedom-of-choice waivers;
- Reducing inappropriate utilization: the use of copayments; and
- Deciding whom to serve: State eligibility provisions.

In addition, policymakers were interested in recent State initiatives in the area of family responsibility. Although there has been no recent Federal legislation in this area, there is growing interest at both the Federal and State levels in developing Medicaid policies which maintain the role of family members as the primary providers of long-term care services.

While the recentness of these changes precludes an evaluation of their impacts at this early date, the study examined what responses State are making to these opportunities and what initial trends are suggested by these responses. HCFA has recently awarded a series of contracts to look at these issues in-depth over a three-year period beginning October 1, 1983.

#### Home and Community-Based Services Waivers

Under Section 2176 of OBRA, States are allowed to apply to HCFA for a special waiver to finance non-medical home and community-based services through Medicaid. In order to receive HCFA approval of their waiver requests, States must demonstrate that total long-term care expenditures under the waiver program will be less than what total long-term care expenditures would have been without the program. In other words, States must demonstrate how the costs of home and community-based services would be more than offset by reductions for other covered Medicaid services (e.g., hospital care, nursing home care).

State responses to the Section 2176 waiver program have exceeded all expectations. As of December 9, 1983, HCFA had received 105 waiver requests from 47 States, 62 of which had been approved, 6 disapproved, and 4 withdrawn. The remaining 33 requests were still pending. Of the 62 which have been approved, 29 waiver programs were targeted to aged/disabled persons, 28 to the mentally retarded, and 5 to the mentally ill. The most commonly applied for services are case management, adult day care, respite care, and habilitation. The large number of programs being targeted to the mentally retarded is not surprising, given the extremely high cost of ICF-MR care and therefore the large potential for achieving Medicaid program savings by reducing utilization of ICF-MRs.

### Inpatient Hospital Reimbursement

To help contain hospital costs in the Medicaid program, OBRA granted States new flexibility in the establishment of inpatient hospital reimbursement methodologies. Under Section 2173, States were allowed to reimburse hospitals only for costs which were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." Prior to this provision, reimbursements were based on "reasonable costs," which generally allowed the hospital considerable freedom to incur costs and pass those costs on to the Medicare and Medicaid programs.

As of early 1982, 17 States had departed from reasonable cost-based methods of hospital reimbursement to alternate reimbursement methods. But of these 17, only 4 had changed reimbursement policies under Section 2173 authority: Illinois, Kentucky, Missouri, and North Carolina. The other 13 States had changed reimbursement methods under HCFA demonstration authority.

The most talked about change in hospital reimbursement is taking place in California, in its new Selective Provider Contracting Program (SPCP), which authorized:

- the appointment of a special hospital negotiator (informally referred to as "Czar") who would act as prudent purchaser for all inpatient hospital services for Medi-Cal enrollees;
- the Department of Health Services to enter into selective contracts with non-institutional providers; and
- private insurance companies and non-profit hospital plans to selectively contract with Preferred Providers, and to restrict policy holders to services rendered through these providers.

### Freedom-of-Choice Waivers

Prior to enactment of OBRA, Medicaid enrollees were generally free to seek medical care from any certified Medicaid provider they wanted. Section 2175 of OBRA relaxed the freedom-of-choice provision in two key ways. First, States could engage in any of the following activities without Secretarial waiver approval:

- competitive bidding arrangements or bulk/volume purchasing for laboratory services and medical devices;
- "locking-out" or restricting the participation of certain providers who had provided poor quality care or medically unnecessary care; and



- "locking-in" certain recipients who had been chronic overutilizers by restricting their care to specified providers.

Second, Section 2175 also permitted four classes of Secretarial waivers to freedom-of-choice provisions:

- waivers to implement primary care case management systems;
- waivers to permit localities to act as central brokers in helping Medicaid recipients choose among competing health plans;
- waivers to allow States to share with recipients, through the provision of additional services, savings resulting from the use of less costly, more cost-effective care; and
- waivers to restrict recipients to receiving non-emergency care from only efficient and cost-effective providers.

As of June 15, 1983, 22 States had submitted a total of 47 waiver applications related to the freedom-of-choice provisions. Of these 47 applications, 25 were approved, 7 were pending, and 14 were either withdrawn or denied. Of the 25 approved waivers, the vast majority (19) involved authority governing primary care case management. Only 4 involved authority regarding shared savings, and 7 involved authority which restricted recipients to efficient and cost-effective care. No waiver involved activity covering central brokers, and several waivers included more than one type of waiver authority.

### Copayments

In an attempt to increase cost-consciousness among Medicaid recipients, TEFRA allowed States to extend limited copayment requirements for certain services to the categorically needy. Prior to TEFRA, States were allowed to impose nominal copayments on (1) optional services for both the categorically needy and the medically needy, and (2) mandatory services for the medically needy only. The passage of TEFRA allowed States to extend "nominal" copayments for certain mandatory services provided to the categorically needy. "Nominal" was defined as between \$0.50 and \$3.00 per service, and copayments could exceed nominal levels only in special cases, where the Secretary waived the nominality requirement.

As of March 1983, 25 States had some form of copayments. Copayments were applied most frequently to drug purchases (19 States), but also to a variety of other services, such as



optometrist, chiropractor, and outpatient services. Most of these copayments were, however, in effect prior to the enactment of TEFRA. Only 3 States appeared to have added copayments on mandatory services for the categorically needy.

It is difficult to discern an overall trend in the use of copayments by State Medicaid programs. From February 1982 to March 1983, 6 States added copayments, 4 States eliminated copayments, and 3 States both added and subtracted copayments. These changes suggest that States are still experimenting with copayment requirements.

### Eligibility

Each of the three major pieces of Medicaid-related legislation enacted between 1980 and 1982 included changes in eligibility provisions. First, there were significant changes under OBRA 1981 which restricted eligibility for AFDC cash assistance nationwide. These AFDC changes of course affected Medicaid enrollment of AFDC recipients.

Other legislative changes affected Medicaid eligibility directly. The most important of these changes were:

- OBRA allowed States the option to deny eligibility to applicants who transferred assets for less than fair market value in the two years prior to application in order to become eligible for SSI and/or Medicaid. Preliminary 1983 data indicate that 30-35 States had adopted this eligibility option, and that four States have imposed even more stringent transfer of asset requirements.
- OBRA allowed States to cover only specific eligibility groups in their medically needy programs and to vary financial eligibility requirements by group. As of 1983, no States appear to have adopted this type of "limited" medically needy program, and it appeared that the only States considering this option were States which currently did not have a medically needy program.
- OBRA also restricted the optional coverage of "Ribicoff" children (poor children in non-AFDC households) by allowing States to set a maximum age for such children, anywhere between 18 and 21. Seven States have used this option to reduce the maximum age of their coverage of Ribicoff children to less than 21 years of age.
- TEFRA allowed States the option to impose liens on the homes of institutionalized Medicaid recipients who are not likely to return home. No States as of this date have moved to exercise this option.

- TEFRA also allowed States to extend eligibility to certain disabled children living at home who would otherwise have been eligible for Medicaid only within an institution. Known as "Katie Beckett" children after the young girl in Iowa whose situation brought this issue to the forefront, TEFRA allowed States to waive deeming requirements for these children if home care would be less expensive and medically and socially appropriate. As of this writing, 11 States had responded to this eligibility option.

### Family Responsibility

Long-term care research has consistently underscored the importance of family and friends in providing long-term care services to impaired elderly and disabled persons. Despite rapidly growing public expenditures for long-term care, it is commonly estimated that over 80% of all long-term care is still provided by these "informal" caregivers.

In recognition of this fact, there is growing interest among Medicaid policy-makers at both the Federal and State levels to develop policies which act as incentives, rather than disincentives, to family-provided care. These policies generally take two approaches: (1) requiring family members of institutionalized Medicaid recipients to pay a portion of nursing home costs; and (2) providing financial incentives to families, either through tax deductions or direct payments, to care for their elderly kin.

While many States have expressed interest in requiring family members of institutionalized recipients to contribute to the cost of care, this policy option has become a politically sensitive issue in many States, and therefore an option which States are approaching cautiously. Only one State, Idaho, has enacted a "family responsibility" program of this type. Put into effect in October of 1983, the program is requiring relatively modest contributions from families with annual incomes more than three times the poverty level. For example, a family of four earning \$30,000 per year would be required to contribute about \$69 per month for the cost of a relative's nursing home care.

Four States -- Idaho, Oregon, Iowa and Arizona -- are also experimenting with tax incentives for family caregiving. Each program is designed differently in terms of who is eligible to take the deduction or tax credit, the amount which can be deducted, and eligibility requirements. Outside the Medicaid program, a number of States have permitted direct payments to family members to provide care, under specified conditions. The primary risk of financial incentive programs is that instead of "purchasing" additional long-term care services, resources will be used to pay for care that would otherwise have been provided in any case without incentives.

## Chapter 2

### RECENT TRENDS IN THE MEDICAID PROGRAM

This chapter presents enrollment, utilization and expenditure trends in the Medicaid program over the ten-year period from 1972 to 1982. The purpose of the chapter is to provide a historical perspective to the recent research findings presented in Chapters 3 through 5, and to the discussion of future directions in the Medicaid program presented in Chapter 6.

The primary data sources for this chapter are annual statistical reports (HCFA Form 2082) submitted by State Medicaid agencies and compiled by HCFA's Bureau of Data Management and Strategy. Although the Medicaid program was initially enacted in 1965, national Medicaid data generally begin with the year 1972 due to problems related to program start-up and data incomparability in years prior to 1972. The diversity of State Medicaid programs, the non-standardization of Medicaid Management Information Systems (MMIS), and the absence of person-based file structures still impose limitations on the quality of these data. However, the quality of national Medicaid data has been constantly improving over the years, particularly for the types of data presented in this chapter, i.e., aggregate data on recipients and expenditures.

#### 2.1 The Medicaid Crisis

"Crisis" is a term which is being increasingly utilized, particularly at the State level, to describe the dramatic rise in Medicaid expenditures over the last ten years. Over this period, Medicaid spending has been the most rapidly rising component of most State budgets, exceeding the rate of growth in State revenues. At the Federal level as well, Medicaid expenditures are increasing at a faster rate than revenues, contributing to budget deficits.

Total Medicaid expenditures (State and Federal) rose from \$6.3 billion in 1972 to \$29.9 billion in 1982, an Annual Compound Rate of



Growth (ACRG) of 16.9% (Exhibit 2-1).<sup>1</sup> In comparison, Federal revenues grew at an ACRG of 11.7% over the same period, and State revenues at an ACRG of 11.4%. Put differently, Medicaid expenditures have been growing 40% faster than the capacity of Federal and State governments to pay for Medicaid services.

The growth in Medicaid expenditures was not constant over this ten year period. The most rapid growth occurred between 1972 and 1975, when expenditure increases averaged over 25% each year. In the latter half of the 1970s and early 1980s, expenditure increases moderated, averaging 13.7%. However, increases in Medicaid expenditures should be viewed within the context of State and Federal revenue growth. For example, while the rate of Medicaid expenditure increase declined substantially between 1981 and 1982 to under 10%, the decline in State and Federal revenues, due to the latest recession, was equally dramatic (also Exhibit 2-1). Thus, the Medicaid funding crisis became particularly acute in several States during the 1981-1982 recession as Medicaid expenditure increases and growing welfare costs significantly outpaced growth in public revenues. For example, total State revenues in Michigan declined from 1981 to 1982 by \$448 million while Medicaid expenditures increased by over \$35 million. State revenues increased in Pennsylvania by \$942 million from 1981 to 1982, but Medicaid expenditure increases took up almost \$400 million (42%) of that new revenue growth. California, faced with a projected shortfall of \$200 million in its 1981-82 Medi-Cal budget, appointed a Medicaid "Czar," who was given the directive to reduce Medi-Cal inpatient hospital costs by \$100 million in 1982-83 through selective contracting with providers. Given these unchecked increases in Medicaid costs, and the pressure such increases put on lagging State revenues, it is therefore not surprising that current initiatives in Medicaid policy have been largely focused on how to limit Medicaid costs while maintaining access and quality.

Medicaid expenditures represent about 10% of total national expenditures for health (Exhibit 2-2). Between 1972 and 1975, Medicaid expenditure growth exceeded the rate of growth in national health care expenditures, while in the latter half of the 1970s, rates of growth in Medicaid and total health care expenditures were approximately equal. It appears that since 1980, the proportion of total health care expenditures paid by Medicaid has been declining

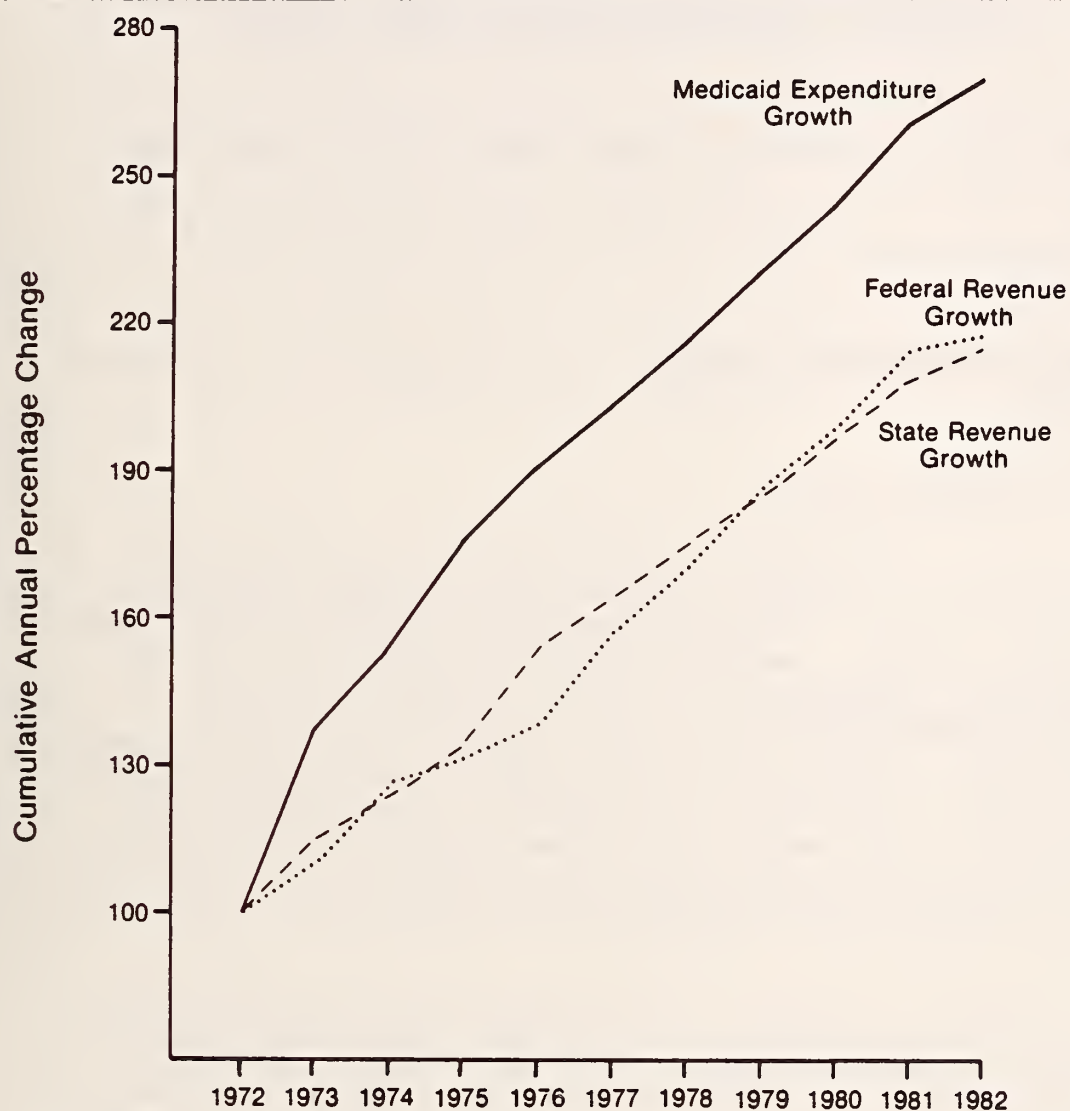
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<sup>1</sup>1982 data. Data are for fiscal years and exclude administrative costs and State "buy-in" costs for dual enrollees, unless otherwise noted. Total Medicaid expenditures for calendar year 1982, including administrative and buy-in costs were \$34.0 billion. See Gibson, R.M., Waldo, D.R. and Levit, K.R. "National Health Expenditures, 1982." Health Care Financing Review 5(1): 1-31, Fall 1983.



# Cumulative Annual Percent Change in Medicaid Expenditures, State Revenues, and Federal Revenues: 1972-1982

1972=100



	Medicaid Expenditures	State Revenues	Federal Revenues
ACRG 1972-1982	16.9%	11.4%	11.7%
ACRG 1972-1975	25.0	11.2	10.4
ACRG 1975-1980	13.7	12.4	13.1
ACRG 1980-1982	13.3	9.3	10.1
Percent change 1980-1981	17.1	12.2	15.9
Percent change 1981-1982	9.6	6.5	3.7

Sources: 2082 data, State Government Finances, and Statistical Abstract of the United States: 1982-1983

slightly. However, this decline should be viewed in the context of enrollment trends in the Medicaid program, as discussed in the following section.

#### Exhibit 2-2

##### Medicaid Expenditures as Percentage of National Health Expenditures: Calendar Years 1972 - 1982

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<u>1972</u>	<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>
9.1%	9.4	9.7	10.7	10.6	10.5	10.5	10.6	10.8	10.6	10.5

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Source: Gibson et al, op. cit. Includes administrative and buy-in costs.

#### 2.2 Enrollment Trends

The rise in Medicaid expenditures cannot be attributed to increases in the number of persons receiving medical assistance through Medicaid. In fact, the number of Medicaid recipients peaked in 1977 at almost 23 million persons (Exhibit 2-3).<sup>2</sup> There were significant increases in the recipient population in the early 1970s, largely attributable to the enactment of the Federal Supplemental Security Income (SSI) program in 1972, which increased the number of aged, blind, and disabled persons eligible for public assistance, and secondarily, for Medicaid. However, since 1977, enrollment in the Medicaid program has actually declined by about 1 million recipients (about 4%). Thus, the proportion of the total U.S. population receiving Medicaid has declined from 10.5% in 1976 to about 9.5% in 1982 (Exhibit 2-4).

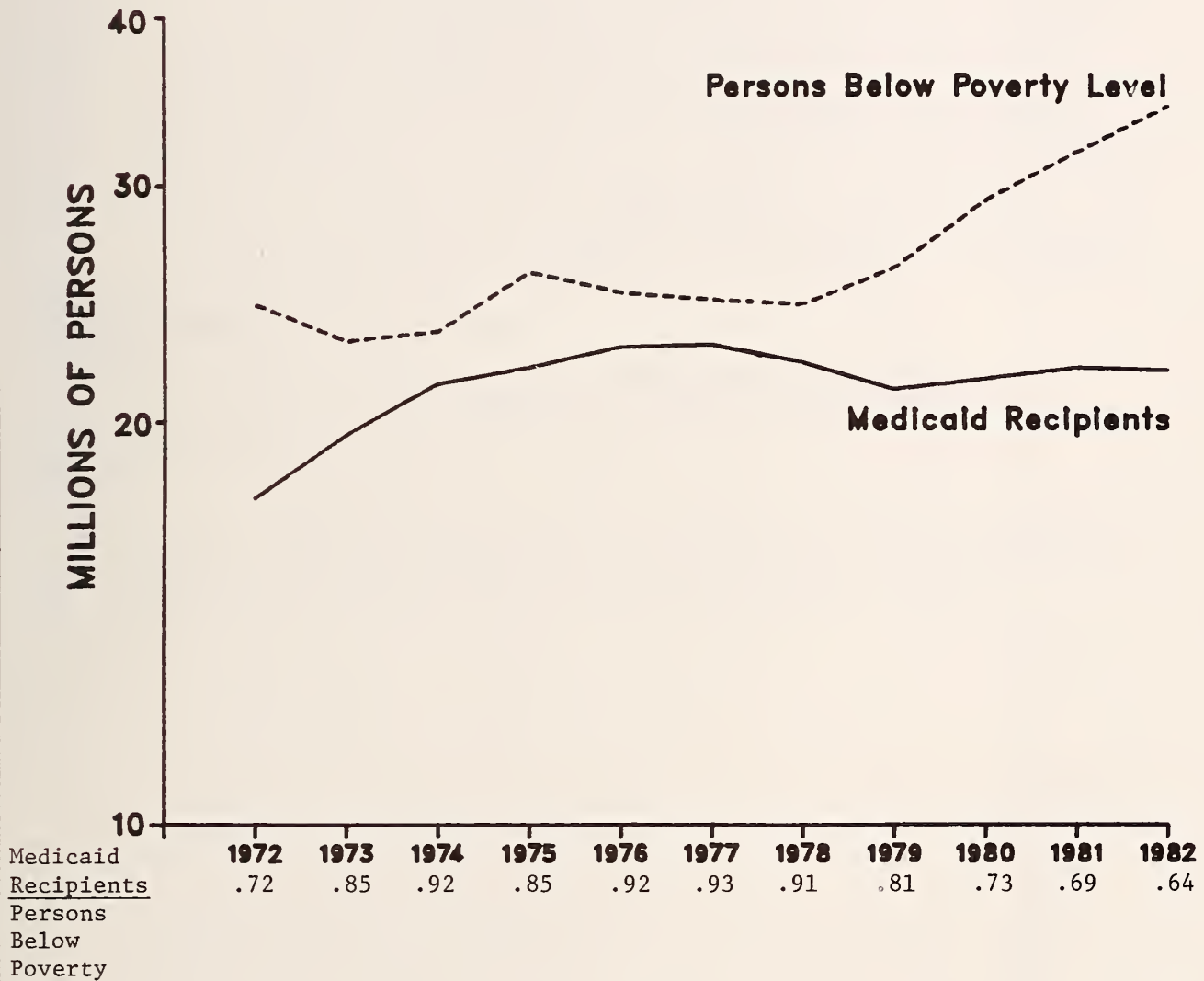
Medicaid enrollment trends in comparison to overall poverty trends are also displayed in Exhibit 2-3. While Medicaid provides medical assistance to people who are poor, Medicaid enrollment trends do not always reflect overall poverty trends, for a number of reasons. Medicaid recipients must also meet categorical criteria, that is, they generally must be aged, blind, disabled, or live in single-parent households with dependent children. Second, participation in Medicaid is greatly influenced by individual States' determinations of what level of poverty is necessary for public assistance payments. Third, not all Medicaid recipients have incomes below the official poverty level. The 1980 Census indicated that only 59% of non-institutionalized persons covered by Medicaid

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<sup>2</sup>Annual statistical reports (2082 data) submitted by States only report the number of persons receiving medical assistance through Medicaid, not the number of enrollees. Estimates of the proportion of Medicaid enrollees who actually receive medical services paid by Medicaid range between 80% and 90%.

Exhibit 2-3

Enrollment Trends: Number of Medicaid Recipients and  
Number of Persons Below Poverty Level: 1972-1982



Sources: 2082 data and Statistical Abstract of the United States: 1982-1983.  
Recipient and poverty data are displayed on a logarithmic scale.

Exhibit 2-4

Proportion of U.S. Population Receiving Medicaid: 1972-1982



Sources: 2082 data and Statistical Abstract of the United States: 1982-1983



had household incomes below the poverty level.<sup>3</sup>

Nonetheless, Exhibit 2-3 shows that the ratio of Medicaid recipients to the number of persons below poverty level in 1982 (.64) was lower than at any other time in the preceding ten-year interval. A more detailed analysis would be necessary to determine the reasons for this declining ratio, such as whether many recent additions to the poverty population are persons who do not meet Medicaid categorical eligibility requirements (e.g., two-parent families) or whether tightened eligibility provisions for SSI, AFDC, and Medicaid are responsible for this decline. Recent poverty data do in fact show that the number of elderly persons living below poverty level declined by 4% between 1980 and 1982, and that the number of married couples living below poverty has been increasing faster than the number of female-headed households living below poverty (Bureau of the Census, 1982). Thus, there is evidence that many recent additions to the poverty population do not meet Medicaid categorical eligibility requirements. There is also continuing controversy over the official definition of the poverty index, which is based solely on money income, and does not include such non-cash benefits as food stamps, subsidized housing, and Medicaid itself.<sup>4</sup>

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<sup>3</sup>U.S. Bureau of the Census, Current Population Reports, series P-60, No. 131. This statistic is supported by NMCUES data which found 61% of non-institutionalized enrollees to be at or below poverty level.

<sup>4</sup>For a discussion of the controversy over the definition of the poverty index see, for example, the statement of David Stockman, OMB Director, before the House Ways and Means Subcommittees on Oversight, and Public Assistance and Unemployment, November 3, 1983.

### 2.3 Enrollment Trends by Eligibility Group

The Medicaid program primarily serves four different groups of poor people: persons over age 65, the disabled, children in AFDC families, and AFDC mothers. The AFDC population comprised about two-thirds of the Medicaid population in 1982, while the aged, blind, disabled and others comprised the remaining one-third.<sup>5</sup>

Trends in the distribution of the Medicaid caseload by eligibility category are presented in Exhibit 2-5. Between 1972 and 1982, the proportion of AFDC children remained relatively unchanged, while the proportion of AFDC adults increased. These changes within the AFDC population are largely attributable to the shrinking size of the average AFDC family unit. The average number of children in AFDC families dropped from 3.0 to 2.1 between 1969 and 1979 (Social Security Administration, 1982). Within the SSI-related groups, aged recipients have declined from about 19% of the Medicaid population to 15%, while the blind and disabled rose from 10% to 13% of the recipient population.<sup>6</sup>

Changes in the distribution of aged and disabled recipients reflect changes in the composition of the SSI population over the same time period (Exhibit 2-6). The aged population receiving SSI declined between January 1974 and December 1982 from 1.9 to 1.5 million recipients. During the same interval, the number of disabled SSI recipients increased by over 75%, from 1.3 to 2.2 million persons.

A number of factors contributed to these SSI enrollment trends during the 1970s. One factor was the rising incomes of elderly persons in general. Largely due to increased Social Security benefits, the proportion of elderly persons living below poverty level declined dramatically over the last decade (Exhibit 2-7). This decline is therefore reflected in the proportion of the aged population receiving Medicaid (also Exhibit 2-7). The improving economic status of elderly persons therefore largely explains why

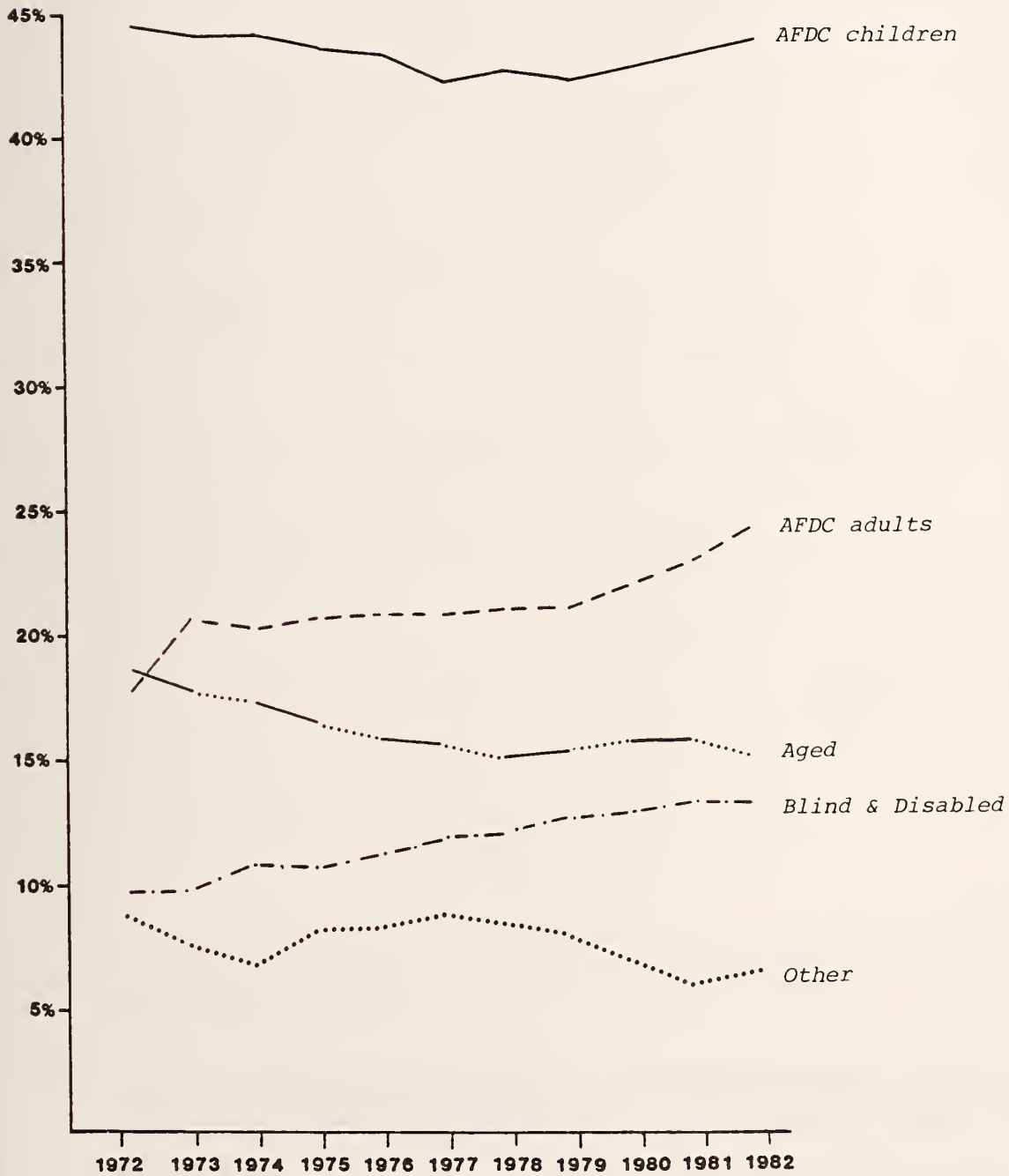
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<sup>5</sup>A small proportion of Medicaid recipients (primarily children in optional coverage groups) are neither AFDC nor SSI-related, and are classified as "Others." This group comprised 6.6% of recipients, and accounted for 2% of expenditures in 1982. For a more detailed discussion of "Other" recipients, see Chapter 3.

<sup>6</sup>The blind comprise only about 0.4% of the Medicaid population (approximately 85,000 persons in 1982).

Exhibit 2-5

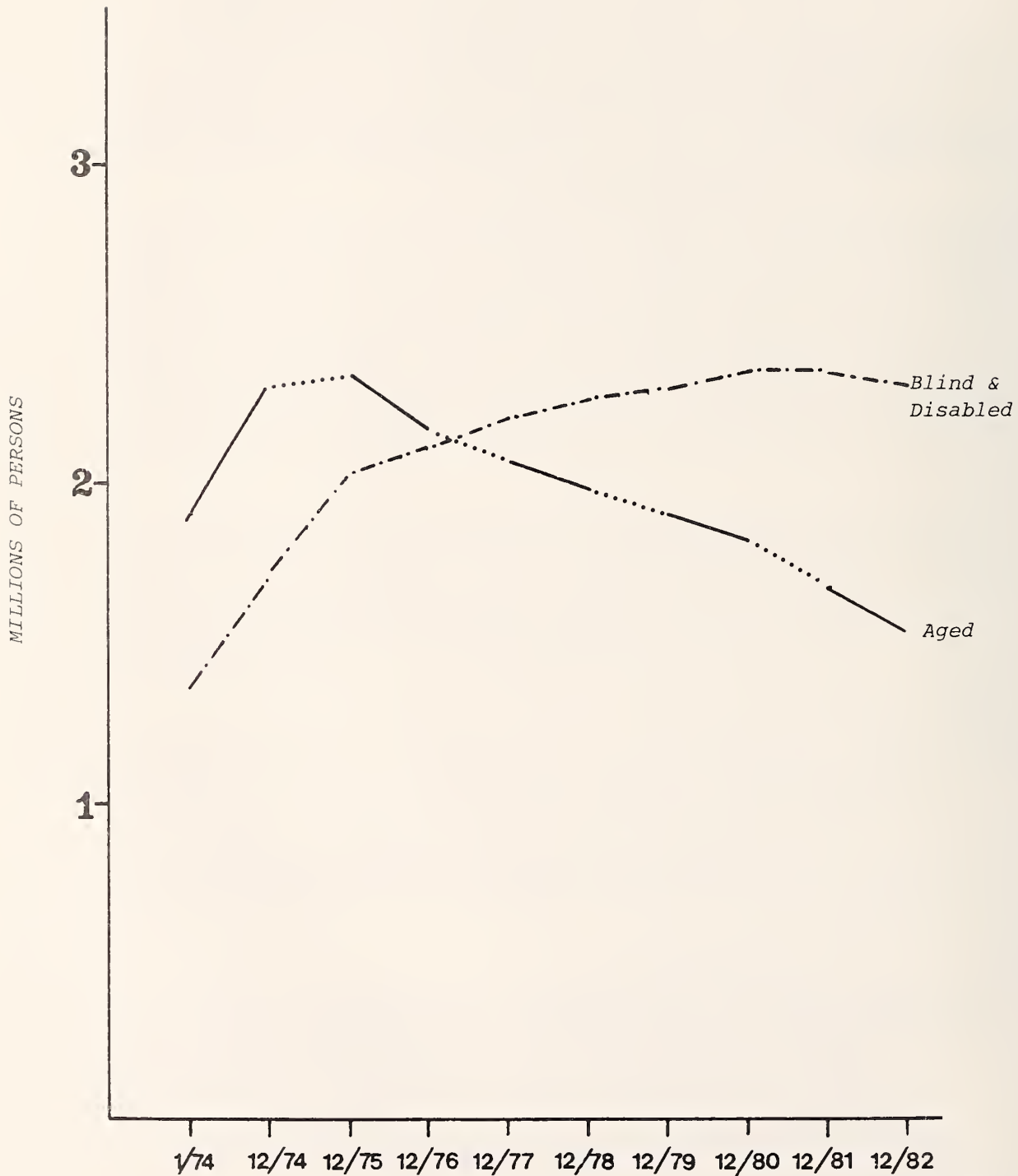
Distribution of Medicaid Recipients by Eligibility Category:  
1972-1982



Source: 2082 data

Exhibit 2-6

Enrollment Trends in the SSI Program: 1974-1982

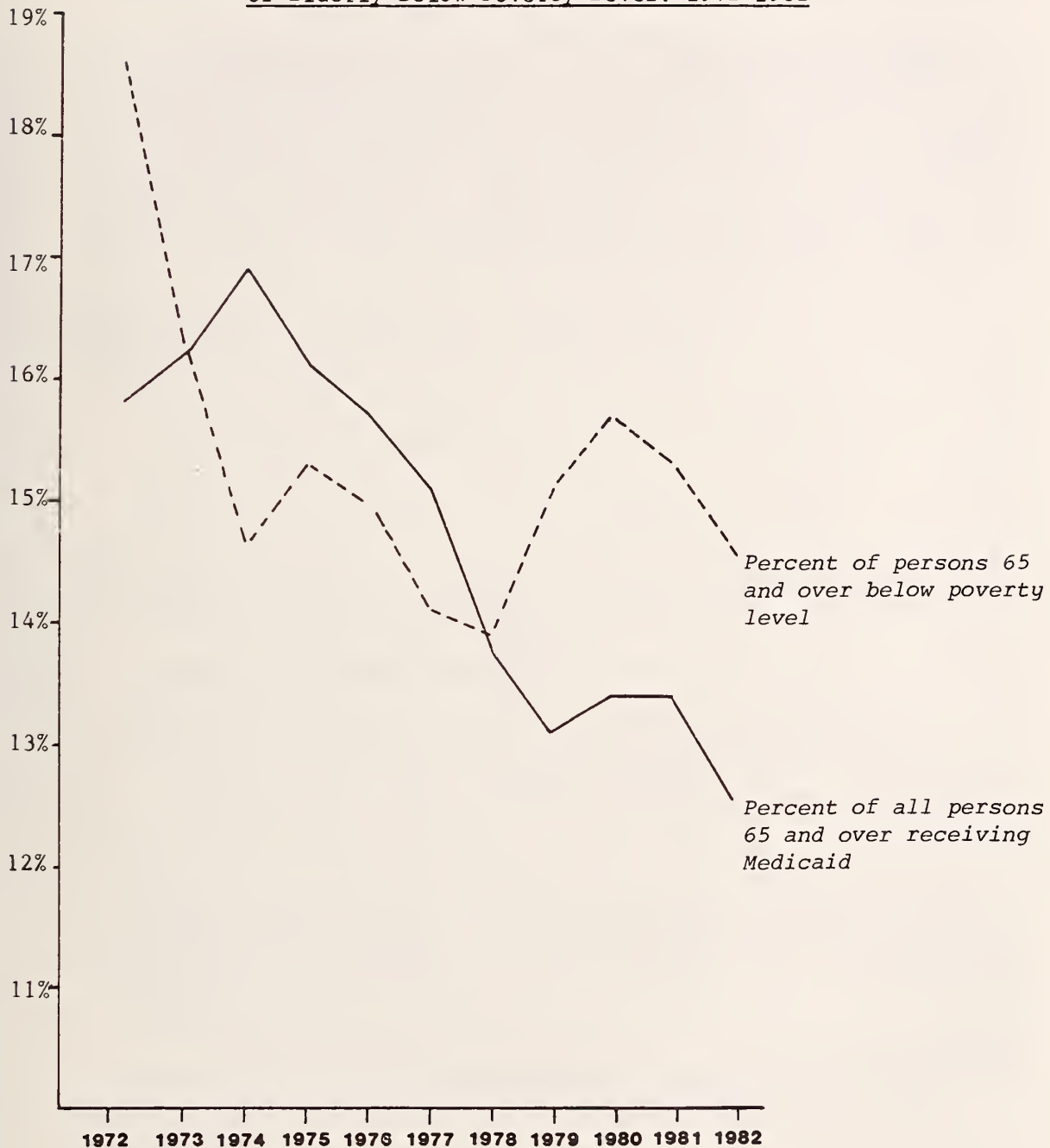


Source: Current Operating Statistics. Social Security Bulletin  
Vol. 46(7):78, July 1983.



Exhibit 2-7

Percent of Elderly Persons on Medicaid and Percent  
of Elderly Below Poverty Level: 1972-1982



Sources: 2082 data and Social Security Bulletin: Annual  
Statistical Supplement, 1982.

the aged Medicaid population increased by only 1.5% between 1972 and 1982, despite a 28% increase in the total elderly population over the same period.

Factors which account for the rise in the SSI disabled population are more difficult to ascertain. One known factor is that at the time the SSI program was enacted in 1972, eligibility was extended to disabled persons under age 18, who had not been covered under the precursory Aid to the Permanently and Totally Disabled (APTD) program. Thus, the number of disabled persons under 18 receiving SSI grew from almost zero in January 1974 to 229,000 by the end of 1980, accounting for about 25% of the total growth in the SSI disabled population over this period.

Another factor in the growth of the SSI disabled population has been the policy to deinstitutionalize mentally disabled persons from public institutions. When mentally retarded or mentally ill persons are institutionalized in non Title XIX-certified State or county institutions, they are ineligible for participation in the SSI program. When served in community settings, or in Medicaid-certified facilities, they are generally eligible for SSI income assistance. Between 1971 and 1977, the number of inpatients in State and county mental hospitals declined by over 48%, from 308,024 to 159,405 persons (National Institute of Mental Health, 1981). And between 1970 and 1980, the number of mentally retarded persons in State-operated facilities declined 27% from 187,897 to 136,298 persons (Krantz, Bruininks, and Clumpner, 1982). Thus, an increasing proportion of mentally disabled persons are being cared for in community-based programs, rendering them eligible for both SSI income assistance and Medicaid, and contributing to the growth of the Medicaid disabled population. The conversion of State institutions for the retarded to Medicaid-certified facilities (ICF-MRs) also has increased the size of the disabled recipient population.

While trends show gradual change in the distribution of the Medicaid population by basis of eligibility, as discussed above, there has been little change in the distribution of the Medicaid population by cash assistance status. Approximately three-fourths of the Medicaid population receives some form of cash assistance payment (i.e., SSI or AFDC). Approximately one-fourth receives medical assistance only.<sup>7</sup> This distribution has remained relatively constant between 1973 and 1982.

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<sup>7</sup>The Medicaid-only population includes persons who are categorically eligible for cash assistance but receive no payments, as well as the medically needy. The medically needy are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid, whose income and/or resources are above the limits for eligibility as categorically needy (AFDC or SSI) but who are within limits set under the Medicaid State plan.

In summary, while the rapid rise in Medicaid expenditures was partially fueled by increasing enrollment during the early 1970s, the number of Medicaid recipients in 1982 was less than in 1975. Recently, Medicaid enrollment has remained relatively stable, despite significant increases in the number of persons in the U.S. living below poverty level. There were discernible trends in the distribution of the Medicaid population by eligibility status between 1972 and 1982. The proportion of the Medicaid population who were aged declined moderately, the proportion who were AFDC adults or disabled increased, while the proportion of AFDC children remained stable. Some of the factors accounting for this changing distribution in the Medicaid caseload include:<sup>8</sup>

- the shrinking size of AFDC family units;
- the improved economic status of the total elderly population; and
- growing enrollment of the SSI disabled population.

The impact of these enrollment trends, as well as other factors, on Medicaid expenditures, is addressed in the following sections.

#### 2.4 Trends in Medicaid Expenditures

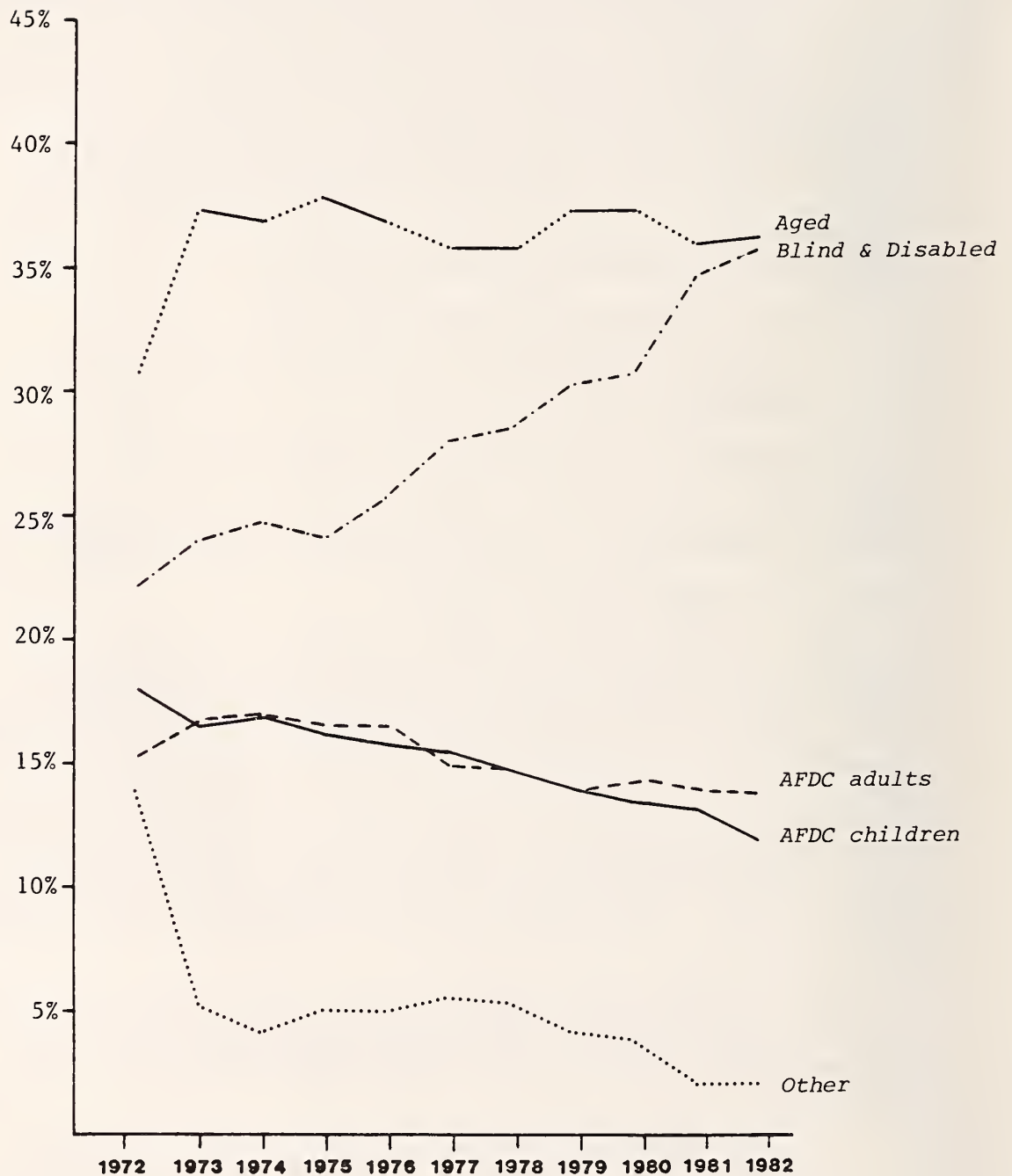
In the previous section, the distribution of the Medicaid caseload across the four major eligibility groups, and changes in this distribution in recent years was discussed. This section looks at the distribution of Medicaid expenditures and recent trends in the distribution of expenditures across eligibility groups. The distribution of expenditures is almost opposite the distribution of recipients. In 1982, the aged, blind, and disabled made up less than 30% of total recipients, yet incurred over 70% of all Medicaid costs. The AFDC population, on the other hand, who made up about 69% of the total population, incurred only 26% of all costs (Exhibit 2-8).

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<sup>8</sup>There is also current debate concerning the relative effects of the 1981-1982 recession and the 1981 OBRA changes on the AFDC caseload. Many contend that the effects have been largely offsetting.

Exhibit 2-8

Distribution of Medicaid Expenditures by Eligibility Category:  
1972-1982



Source: 2082 data



Distribution trends in expenditures show that while the aged comprised a declining portion of the Medicaid population during most of the 1970s, their proportion of total Medicaid expenditures remained relatively constant, between 35 and 37 percent. The most dramatic trend again concerns the blind and disabled. While the proportion of Medicaid recipients who were blind and disabled increased only from 10% to about 13.5%, their proportion of expenditures incurred rose from 22% to 34.5%.

The growth in total Medicaid expenditures by eligibility status from 1972 to 1982 is shown in Exhibit 2-9. Payments for SSI-related recipients increased at an Annual Compound Rate of Growth of 20.5%, compared to an ACRG of 13.9% for AFDC-related recipients. This difference in expenditure growth between the two groups is not attributable to enrollment trends. The ratio of AFDC-related recipients to SSI-related recipients has remained stable (2.5 to 1.0) over the last ten years. Rather, it is the difference in increased costs per recipient which explains the higher rate of expenditure growth for SSI-related recipients (Exhibit 2-10). Increases in the average cost per AFDC-related recipient (10.4% ACRG) have approximated the rise in the medical care component of the Consumer Price Index (9.5% ACRG). Average costs for SSI-related recipients, on the other hand, have increased at almost twice the inflation rate (17.9%). Thus, it appears that it is the changing utilization and expenditure patterns of SSI-related recipients which have been driving real dollar expenditure growth in the Medicaid program in recent years.

## 2.5 Distribution of Expenditures by Type of Service

Most Medicaid costs are either for hospitals or nursing homes (Exhibit 2-11). In 1982, nursing home costs comprised about 43% of the Medicaid budget, while inpatient hospital costs comprised another 30%. Ambulatory care, including physician services, made up about 21% of all costs, while laboratory and radiological services, and prescription drugs, comprised the remaining 6%.

Payments for nursing home care have been increasing at a greater rate than payments for inpatient hospital services and for other covered services (Exhibit 2-12). Therefore, nursing home costs are consuming an ever-increasing proportion of the total Medicaid budget (Exhibit 2-13). In FY 1973, the first year for which national data on nursing home expenditures are available, payments to nursing homes comprised 35% of all Medicaid costs.<sup>9</sup> By 1982, this proportion had increased to 43%.

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<sup>9</sup>Prior to FY 1973, intermediate care facilities were still administered under Federal-State cash assistance programs.

Exhibit 2-9\*

Total Medicaid Expenditures by Eligibility Group: 1972-1982

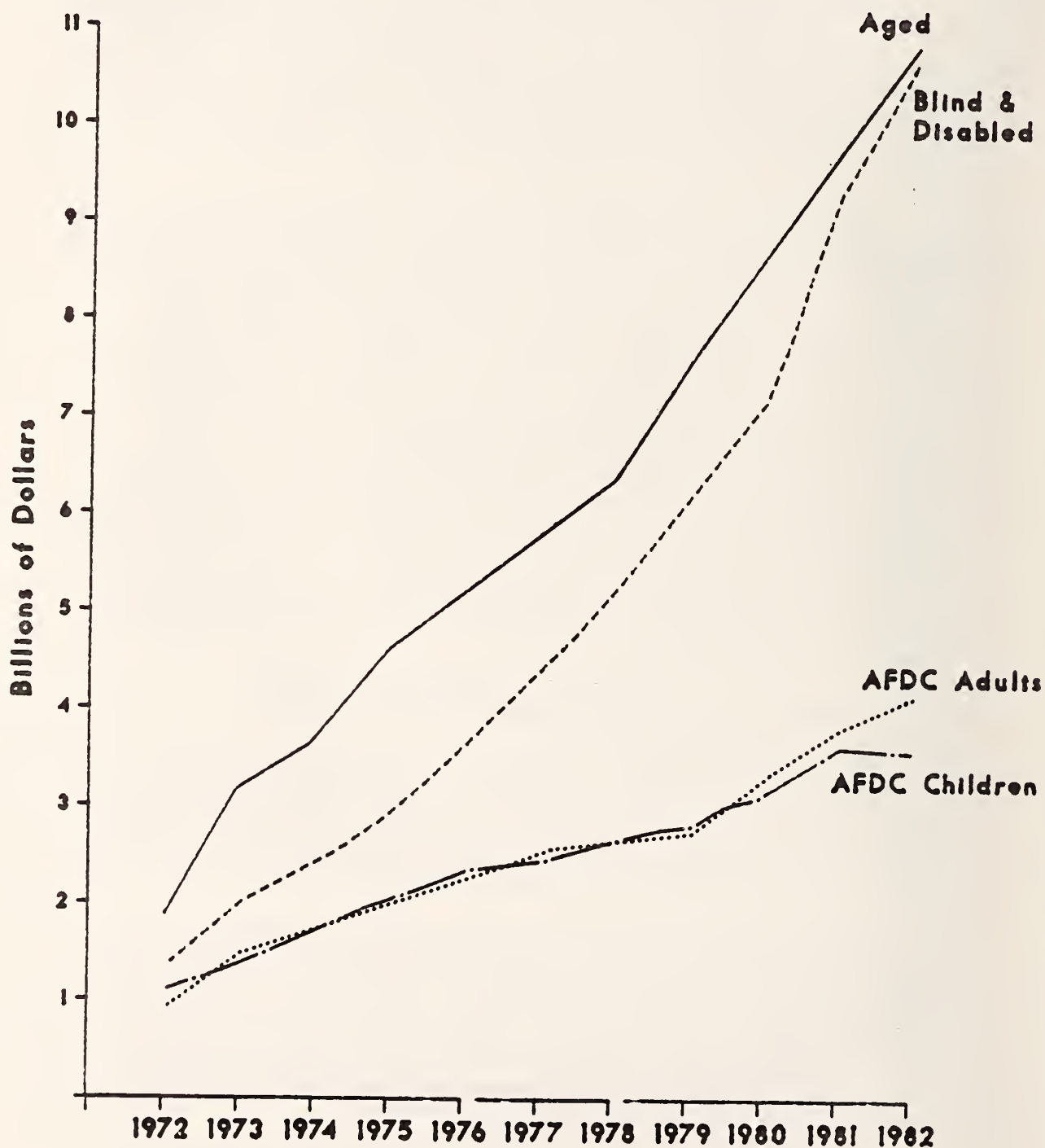
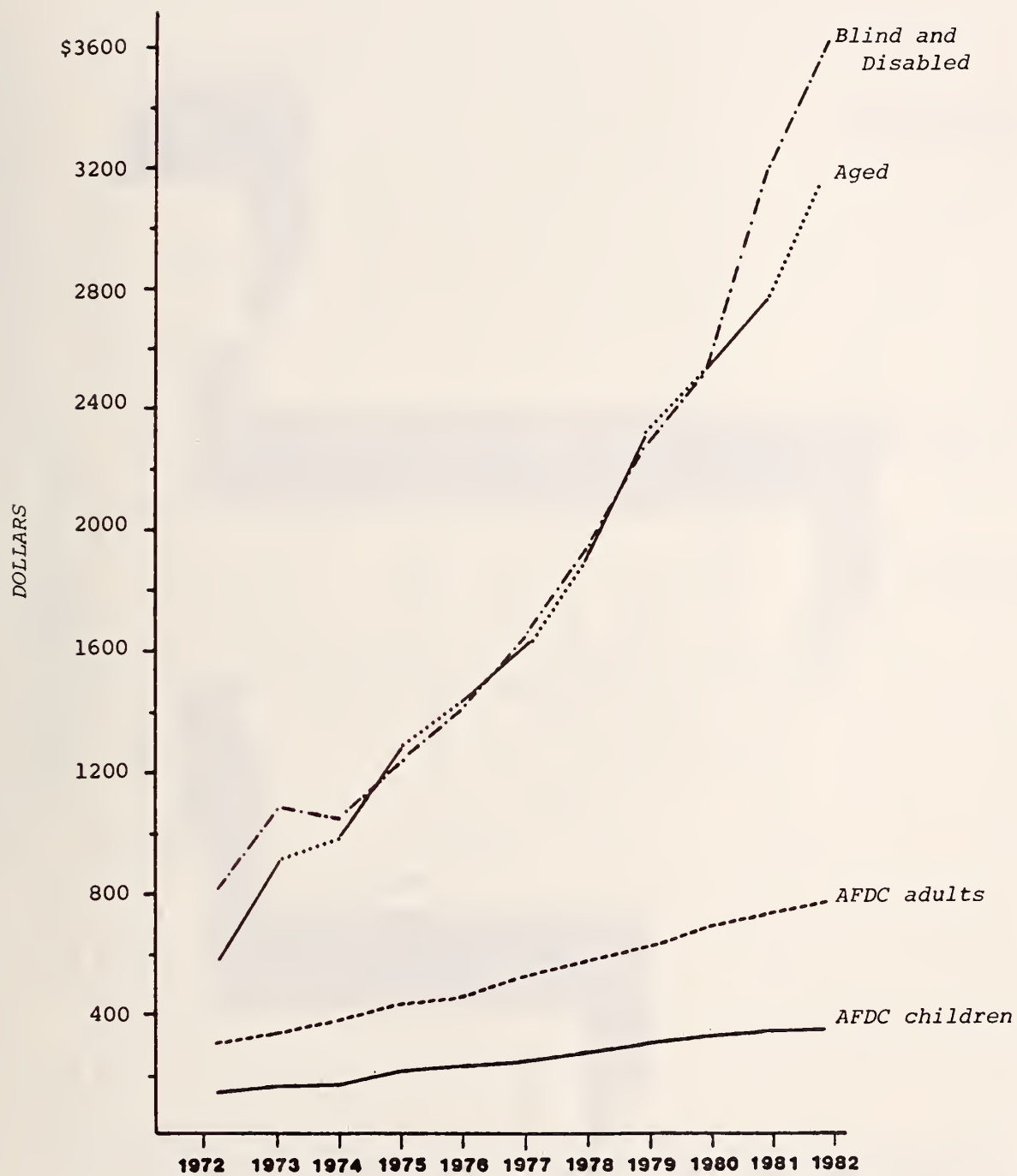


Exhibit 2-10

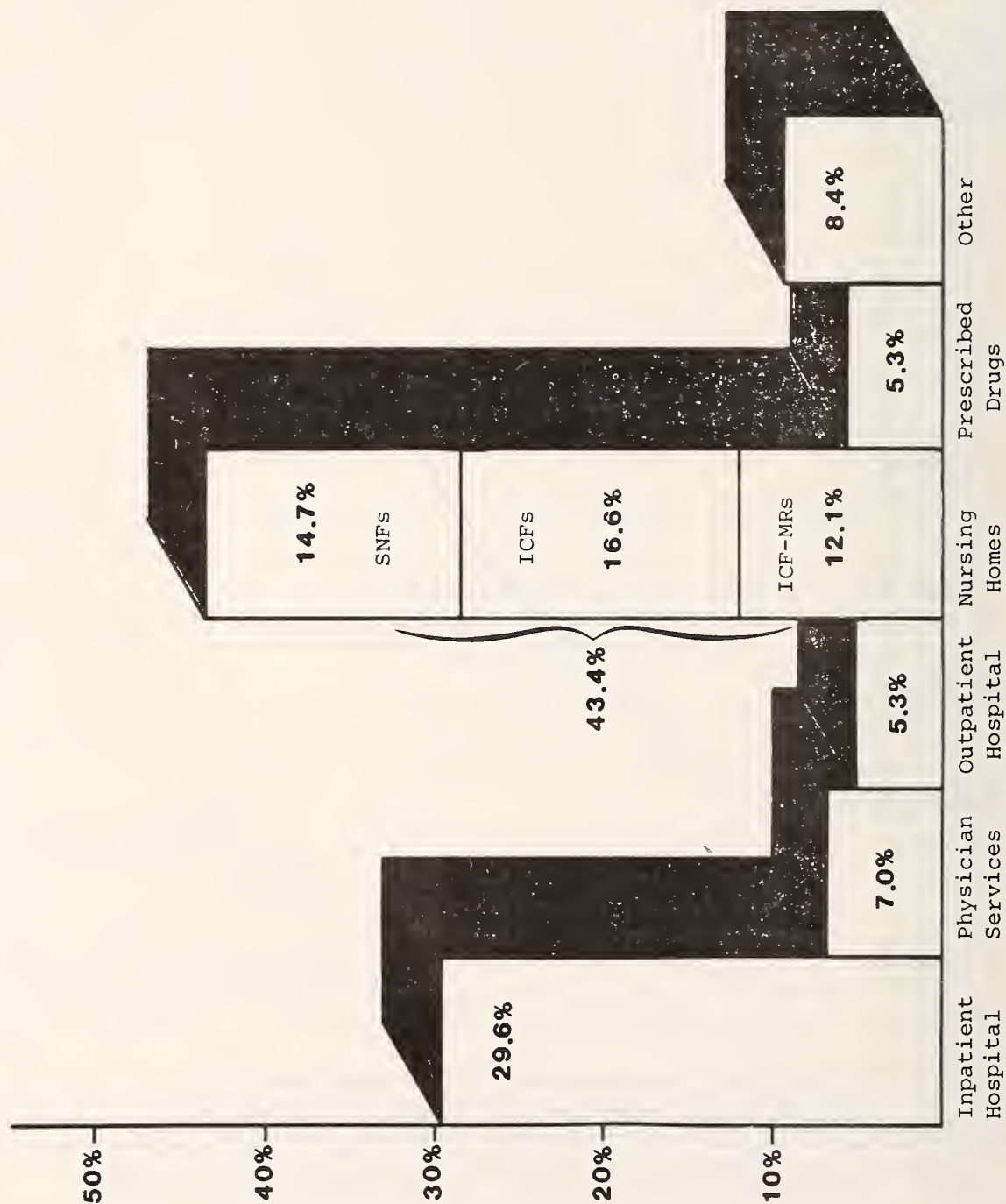
Average Payment Per Recipient by Eligibility Category:  
1972-1982



Source: 2082 data

# Exhibit 2-11

## Distribution of Medicaid Payments by Type of Service: 1982

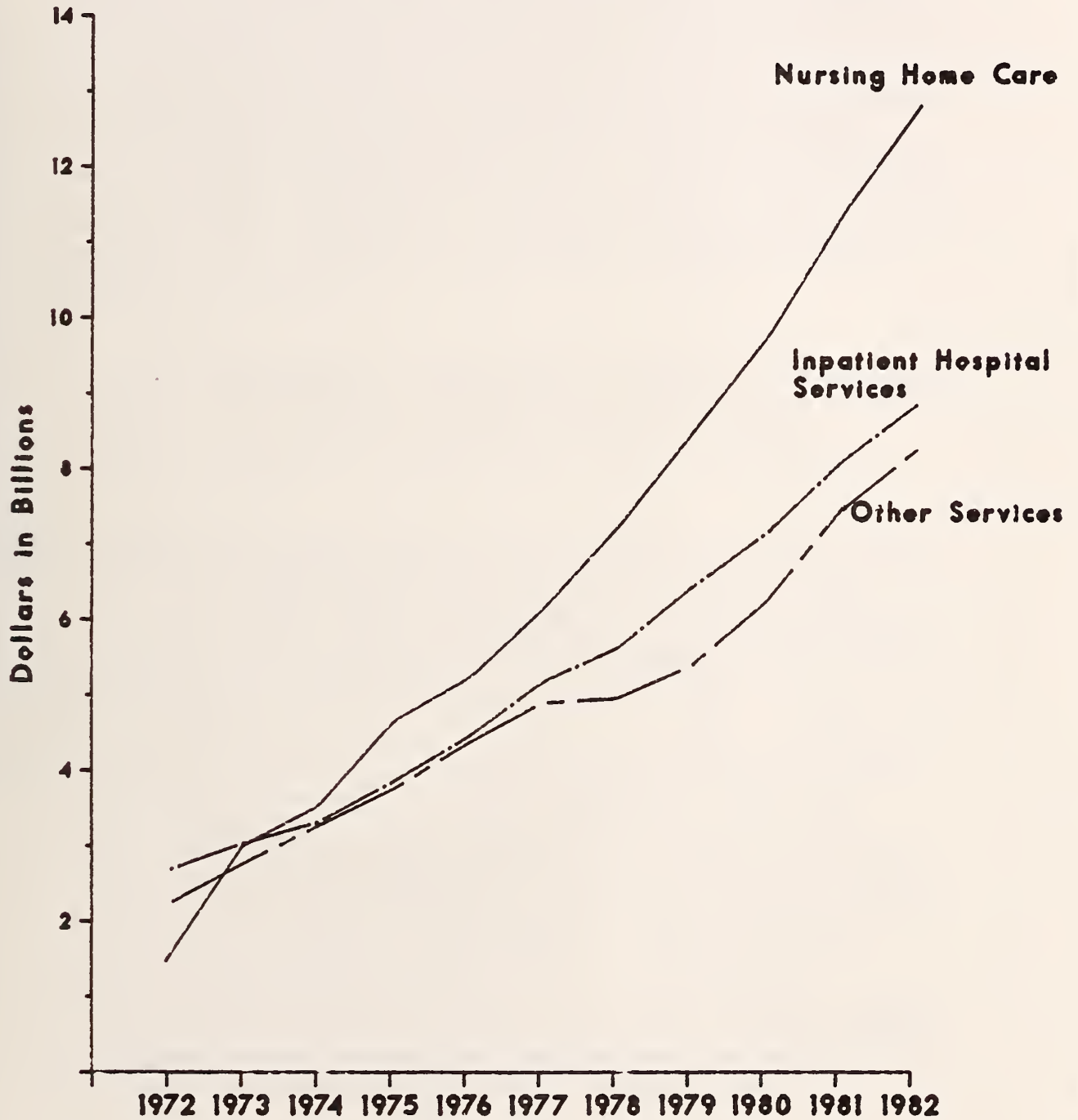


Source: 1982 2082 data



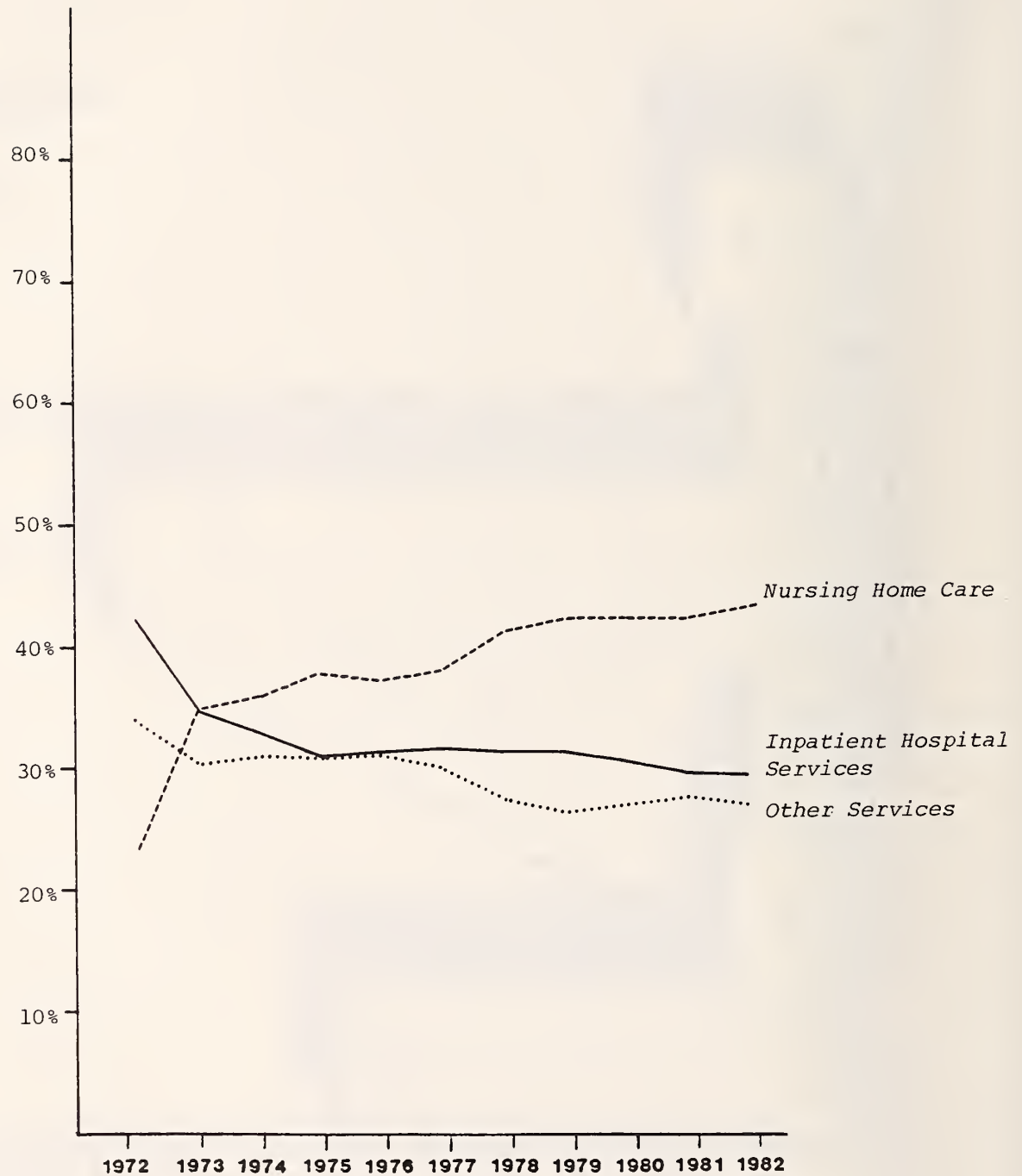
Exhibit 2-12

Total Medicaid Expenditures by Summary Service Category: 1972-1982



Source: 2082 data

Distribution of Medicaid Expenditures by Summary  
Service Category: 1972-1982



Source: 2082 data

Two major factors contributing to the growth of nursing home costs are (1) the aging of the elderly population; and (2) the rapid development of Intermediate Care Facilities for the Mentally Retarded (ICF-MRs). Between 1972 and 1981, the total U.S. population grew by 10%, and the total elderly population grew by 25% (Bureau of the Census, 1982). However, the "very old" age cohort, persons 85 years of age and over, the group at highest risk for institutionalization, grew by 53% over this same period, from 1.5 million to 2.4 million persons. This increase in the "very old" population is attributable not only to the large number of persons entering the elderly age cohort, but significant declines in mortality among the elderly, particularly among the over-85 age cohort, during the 1970s (Fingerhut, 1982). Thus, not only has the number of persons becoming old increased rapidly, but even after becoming old, the elderly are living longer than they had previously. And as mortality has declined, the number of elderly living, and living longer, at high levels of impairment has increased dramatically.

Consequently, while the total number of aged Medicaid recipients has declined in recent years, the number of aged Medicaid recipients in nursing homes has continued to rise. These statistics do indeed suggest that the composition of the aged Medicaid population is gradually evolving toward an older and more impaired group of persons.

It is noteworthy, however, that the growth in the aged Medicaid nursing home population has also lagged behind overall demographic trends. The number of aged nursing home recipients receiving Medicaid increased by about 11% from 1975 to 1982, while the total elderly population increased by almost 20%. Thus, the proportion of all elderly persons in nursing homes and on Medicaid declined from 45 per thousand in 1975 to 42 per thousand in 1982.

The other major factor in the growth of payments for nursing home care has been the rapid growth of ICF-MRs, and the extremely high cost of ICF-MR care. The ICF-MR program was added to the Medicaid program as part of the 1971 amendments to the Social Security Act, and regulations implementing the program were first issued in January 1974. Since that time there has been both rapid development of new ICF-MRs and conversion of State institutions for the mentally retarded to ICF-MR standards. Advocacy groups and States have both pushed for development of ICF-MRs since (a) Medicaid standards improved the quality of care provided institutionalized mentally retarded persons; and (b) States saved money by securing Federal Financial Participation (FFP) for ICF-MR facilities, whereas non-certified State hospitals are generally 100%

State-funded. A recently conducted census of ICF-MRs found 1,853 certified facilities as of June 30, 1982 serving an average daily census of approximately 147,000 mentally retarded persons (University of Minnesota, 1983). Consequently, payments for ICF-MR care increased from \$203 million in 1974 to \$3.6 billion in 1982, an ACRG of 43.3%. In fact, if payments for ICF-MRs are totally excluded, nursing home payments for SNF and ICF care would have comprised the same proportion of all Medicaid expenditures in 1982 (34%) as in 1973. Put otherwise, the increasing proportion of Medicaid expenditures spent on nursing home care is attributable entirely to the growth in expenditures for ICF-MRs. Indeed, one could conclude that expenditures for SNF and ICF care have been remarkably constrained in light of demographic trends over the last ten years. It is possible that the growth of the nation's elderly population and the improved economic status of the elderly have been large offsetting factors in affecting nursing home utilization and expenditures for the aged in the Medicaid program.<sup>10</sup>

## 2.6 State Variations in Medicaid Expenditure Growth

As indicated previously, Medicaid expenditures have been rising at a faster rate than State revenues in the last decade. In most States, Medicaid expenditures are the fastest growing component of the State budget. At a minimum, this means that annual increased expenditures for Medicaid are taking a disproportionate share of new revenues each fiscal year. On the other hand, to the extent that increased Medicaid expenditures represent cost shifting from 100% State-funded facilities/programs to Medicaid funding, the overall impact on State budgets is overstated, since increased Medicaid expenditures are partially offset by reductions in other budget areas.

There has been significant variation in Medicaid expenditure increases across States. Since 1975, Medicaid expenditures have increased at an ACRG of 13.5%. At the State level, the annual rate of growth has varied from a low of 10.2% in Illinois to a high of 28.9% in Alaska. However, expenditure increases in the Medicaid program must be presented in the context of growth in State

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<sup>10</sup>For a more detailed discussion of nursing home recipients and expenditures in the Medicaid program, see Chapter 4.



revenues, in order to account for State variations in population changes and economic growth. A more meaningful statistic is the difference between the growth of Medicaid expenditures and the growth in State revenues (Exhibit 2-14). Overall, since 1975, Medicaid expenditure growth has outpaced State revenue growth by 2.0% annually. However, as Exhibit 2-14 shows, two-thirds of all States have experienced larger shortfalls. West Virginia has experienced the largest shortfall of all, with Medicaid expenditure increases exceeding State revenue growth by over 12% each fiscal year. It has been the larger, more populous, States which have been able to keep Medicaid budget increases approximately equal to the rate of growth in State revenues. In only four States (Michigan, Wyoming, Oklahoma, and Alaska) have State revenues increased at a greater rate than Medicaid budgets.

## 2.7 Summary

Over the last ten years, Medicaid expenditures have been increasing at an Annual Compound Rate of Growth of 16.9%, totalling almost \$30 billion in 1982. Medicaid expenditures have been consistently growing at a higher rate of growth than Federal and State revenues, so that Medicaid, as a proportion of Federal and State outlays, is increasing. However, the most rapid growth in Medicaid occurred during the early portion of the last decade, and recent increases have moderated somewhat.

The rise in Medicaid expenditures is largely attributable to increases in costs per recipient, not to increases in enrollment. The average payment per Medicaid recipient increased at an ACRG of 14.3% between 1972 and 1982, from \$358 to \$1,363. In comparison, the medical care component of the Consumer Price Index rose at an ACRG of 9.5% over the same period (Exhibit 2-15). Thus, only about half the increase in average costs per recipient can be attributed to overall inflationary trends in the health care system. The remaining increase is generally divided among three other factors:

- increases in utilization of Medicaid services per recipient;
- increases in the intensity of service provided per unit of service; and
- price increases in excess of the inflation level.

Costs per recipient have increased at a far greater rate for aged and disabled recipients than for AFDC-related recipients. Increases in average costs per AFDC-related recipient have more closely approximated the inflation rate, while increases in average costs per SSI-related recipient have been almost twice the inflation rate. Increases in the overall costs per recipient cannot be

## Exhibit 2-14

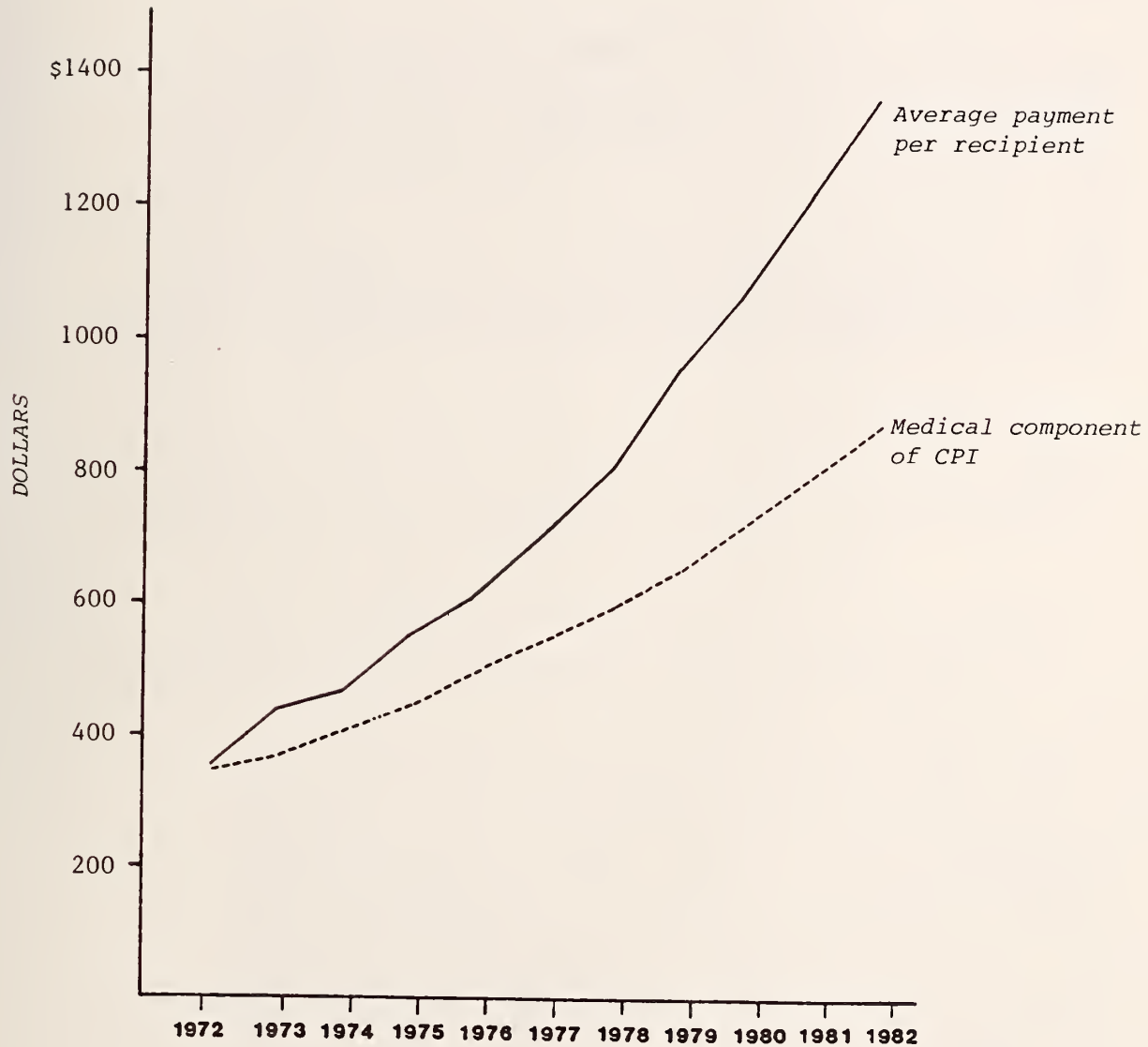
ACRG in State Revenues and Federal/State Medicaid Expenditures,  
by State: 1975-1982

	ACRG Revenues (1975-1982)	ACRG Medicaid Expenditures (1975-1982)	ACRG Revenues - ACRG Medicaid (1975-1982)
All States	11.5%	13.5%	-2.0%
West Virginia	10.4	22.7	-12.3
Missouri	10.1	21.3	-11.2
Tennessee	10.6	21.3	-10.7
Iowa	9.9	19.7	-9.8
Louisiana	12.2	22.0	-9.8
Delaware	11.5	21.1	-9.6
Hawaii	9.8	19.0	-9.2
South Dakota	10.8	19.8	-9.0
Kentucky	10.7	19.1	-8.4
South Carolina	12.2	20.5	-8.3
Florida	10.5	18.1	-7.6
Indiana	9.0	16.3	-7.3
Ohio	12.3	19.6	-7.3
Minnesota	10.6	17.6	-7.0
Nevada	15.4	22.1	-6.7
Maine	10.1	16.7	-6.6
New Hampshire	10.8	17.4	-6.6
North Carolina	10.2	16.8	-6.6
Virginia	10.5	16.8	-6.3
Mississippi	10.3	15.9	-5.6
Arkansas	10.7	16.2	-5.5
Montana	11.7	16.8	-5.1
Vermont	9.1	14.0	-4.9
Idaho	10.4	14.6	-4.2
North Dakota	11.8	15.9	-4.1
Alabama	11.0	14.8	-3.8
Utah	14.4	18.1	-3.7
Rhode Island	12.2	15.8	-3.6
Pennsylvania	9.3	12.8	-3.5
Nebraska	10.5	13.9	-3.4
Connecticut	11.8	15.2	-3.4
New Mexico	15.6	18.9	-3.3
Colorado	10.7	13.9	-3.2
Kansas	10.3	12.5	-2.2
Massachusetts	11.4	13.6	-2.2
Oregon	12.3	14.2	-1.9
Wisconsin	10.9	12.4	-1.5
Maryland	10.9	12.1	-1.2
Washington	12.3	13.4	-1.1
Georgia	11.1	12.1	-1.0
New York	9.9	10.9	-1.0
California	12.3	13.1	-0.8
Texas	13.6	14.1	-0.5
Illinois	9.8	10.2	-0.4
New Jersey	13.1	13.2	-0.1
Michigan	11.2	11.0	+0.2
Wyoming	21.9	21.6	+0.3
Oklahoma	15.2	14.4	+0.8
Alaska	35.7	28.9	+6.8

Sources: 2082 data file and U.S. Bureau of the Census, State Government  
Finances

Exhibit 2-15

Average Payment Per Medicaid Recipient in Comparison  
to Increase in Medical Component of CPI: 1972-1982



Sources: 2092 data and Social Security Bulletin, Current Operating Statistics.

attributed to changes in distribution of the Medicaid caseload across these two groups, since aged and disabled recipients comprised the same proportion of the Medicaid population in 1982 as they did in 1972.

These data suggest that while the enrollment of aged and disabled Medicaid recipients has not increased dramatically, that the changing characteristics and service utilization patterns of these eligibility groups may explain why their average costs are rising so rapidly. It may be that those aged and disabled persons who do qualify for medical assistance under Medicaid are becoming older, sicker and/or more disabled, and therefore in need of more costly services. Given that increases in the annual cost of serving aged and disabled recipients appear to be driving total Medicaid expenditure increases, closer examination of the characteristics and utilization patterns of the SSI-related population appears warranted.



## Chapter 3

### ELIGIBILITY

One of the most critical policy areas within Medicaid is eligibility. Probably no other area of Medicaid policy is as complex and as little understood. Part of the problem is that much of Medicaid eligibility policy is decided for cash assistance purposes. Thus, a perception has often existed that eligibility issues are not a Medicaid concern. However, understanding of the importance of eligibility to Medicaid is increasing. It is becoming recognized that Medicaid budgets are as affected by the size and (perhaps even more) by the composition of the eligible population as they are by increased utilization and medical prices.

Although the Federal government has a strong role in defining the parameters of eligibility policy, much of Medicaid eligibility decisionmaking is left to the States. Two policy areas are especially important in State decisionmaking about eligibility:

- First, States have to decide which groups of people they will include. By law, a State must cover all AFDC recipients. They do not have to cover all SSI recipients automatically, but most do. Probably the most significant eligibility decision a State makes is whether to cover the medically needy group. By including the medically needy, a State opens up Medicaid to categorically-related persons<sup>11</sup> of any income level, assuming their medical bills are large enough and other criteria are met. States can also choose among several other optional coverage groups. However, Medicaid's categorical requirements preclude coverage of all the poor by States under the Federal/State Medicaid program.

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<sup>11</sup>The medically needy still have to meet the categorical requirements of the AFDC or SSI program, i.e., they must be members of families with dependent children (AFDC-related) or aged, blind, or disabled (SSI-related).

- The second critical policy area that States have to decide upon is the financial criteria they will use in determining eligibility. Of particular importance are the payment and income limits which are established. This is an area of enormous flexibility. States are essentially free to set AFDC payment levels wherever they want. Minimum SSI payment levels are Federally-determined, but States are free to supplement them as they wish. The income levels used for the medically needy are tied by Federal regulation to where States set their AFDC levels. Separate income levels can be used for the institutionalized, but there are Federal regulations limiting the maximum level that can be used.

There are many additional eligibility-related decisions States make such as those related to liquid asset levels, accounting periods, length of eligibility, allowable living arrangements, relative responsibility provisions, and transfer of asset prohibitions, but the key State eligibility decisions relate to coverage groups and financial levels.

Each of these areas is being seriously scrutinized as policymakers seek to bring costs under control. In many respects, many of the past policy decisions on Medicaid eligibility have been stabs in the dark. Surprisingly little is known about how specific eligibility policies affect enrollment and costs. Data and analysis relating eligibility practices to utilization and expenditure levels have only recently started to be available.

Not surprisingly then, strong interest was expressed by Congressional and Federal agency staffs in obtaining more and better data on state eligibility policy decisions and analysis of the effects of these decisions on the size and characteristics of the Medicaid population and on program expenditures. This chapter attempts to respond to their concerns.

In Section 3.1 which follows, an overview of State eligibility practices for Medicaid is presented, based on comprehensive State Medicaid program characteristics data collected for 1982. This section does not attempt to review the entire gamut of State eligibility policy decisions. Instead it focuses on those options which are the key parameters of State eligibility policies for Medicaid:

- Whether or not a State covers the "medically needy"
- The extent to which a State makes aged, blind, and disabled SSI cash assistance recipients automatically eligible for Medicaid

- What optional coverage groups a State includes, in particular:
  - families with unemployed parents (AFDC-U)
  - all low-income children not eligible for AFDC
- Where a State sets payment and income levels for the categorically needy and the medically needy

In Section 3.2, several sources of program data for FY 1982 on State Medicaid programs are analyzed to determine what the potential impact of these various individual eligibility decisions appears to be. States are analyzed to determine if a correlation exists between specific eligibility policies and Medicaid enrollment and expenditure patterns.

Then in Section 3.3, an attempt is made at an overall assessment of the impact of eligibility provisions on Medicaid enrollment and expenditures. This assessment utilizes a classification scheme of State Medicaid programs according to the scope of their eligibility provisions. In effect, States are grouped according to the "comprehensiveness" of their eligibility coverage for Medicaid, with an analysis of what impact various levels of coverage appear to have on program enrollment and expenditures.

Section 3.4 utilizes recently developed person-based Medicaid data (from the Tape-to-Tape data base) to permit a detailed and in-depth analysis of enrollment and utilization patterns by eligibility group in two States -- Michigan and New York. While these two States are not representative of the range of Medicaid programs with regard to eligibility policies, they include almost all the optional groups available to States and thus are a source of more detailed information on differences among various eligibility groups. Of special interest, the Michigan and New York data permit the calculation of annual Medicaid costs by recipient person-years of enrollment, rather than just the number of recipients. These data also allow analysis of the high utilizer population for these two States.

Finally, Section 3.5 provides a summary of the study findings with regard to eligibility evaluation concerns.

### 3.1 Overview of State Eligibility Practices

Exhibits 3-1 and 3-2 depict State eligibility practice along the four important dimensions cited above. Exhibit 3-1 shows whether or not States have a medically needy program, how they treat

Exhibit 3-1

Selected Eligibility-Related State Medicaid Program Characteristics - 1982

	Medically Needy Program	Automatic Eligibility of SSI Recipients - No Separate Applications	AFDC-U	MA 18-21
ALABAMA		X		X
ALASKA				
ARKANSAS	X	X		X
CALIFORNIA	X	X	X	X
COLORADO			X	
CONNECTICUT	X		X	X
DELAWARE		X	X	
DISTRICT OF COLUMBIA	X	X	X	X
FLORIDA		X		
GEORGIA		X		X
HAWAII	X		X	X
IDAHO				X
ILLINOIS	X		X	
INDIANA				
IOWA		X		X
KANSAS	X		X	
KENTUCKY	X	X	X	X
LOUISIANA	X	X		X
MAINE	X	X	X	X
MARYLAND	X	X	X	X
MASSACHUSETTS	X	X	X	X
MICHIGAN	X	X	X	X
MINNESOTA	X		X	X
MISSISSIPPI				
MISSOURI			X	X
MONTANA	X	X		X
NEBRASKA	X		X	
NEVADA				X
NEW HAMPSHIRE	X			
NEW JERSEY		X	X	X
NEW MEXICO		X		
NEW YORK	X	X	X	X
NORTH CAROLINA	X			
NORTH DAKOTA	X			X
OHIO			X	
OKLAHOMA	X			X
OREGON				X
PENNSYLVANIA	X	X	X	X
RHODE ISLAND	X	X	X	
SOUTH CAROLINA		X		
SOUTH DAKOTA		X		
TENNESSEE	X	X		X
TEXAS		X		
UTAH	X			X
VERMONT	X	X	X	X
VIRGINIA	X			
WASHINGTON	X	X		
WEST VIRGINIA	X	X	X	
WISCONSIN	X	X	X	X
WYOMING		X		
	30	29	24	29

Source: Analysis of State Medicaid Program Characteristics, 1982. La Jolla Management Corporation, December 1982.



Exhibit 3-2

Selected Payment and Income Levels of State Medicaid Programs - 1982

	<u>AFDC PAYMENT STANDARD</u> <u>FAMILY OF 2</u>	<u>SSI LEVEL</u> <u>AGED COUPLE</u> <u>LIVING INDEPENDENTLY</u>	<u>MEDICALLY NEEDY LEVEL</u> <u>2 PERSONS</u>
ALABAMA	\$89	\$397	
ALASKA	\$508	\$638	
ARKANSAS	\$133	\$397	\$158
CALIFORNIA	\$408	\$815	\$475
COLORADO	\$247	\$674	
CONNECTICUT	\$347	\$491	\$417
DELAWARE	\$197	\$397	
DISTRICT OF COLUMBIA	\$225	\$427	\$436
FLORIDA	\$150	\$397	
GEORGIA	\$161	\$397	
HAWAII	\$390	\$421	\$400
IDAHO	\$245	\$444	
ILLINOIS	\$250	\$467	\$250
INDIANA	\$222	\$397	
IOWA	\$292	\$397	
KANSAS	\$272	\$397	\$390
KENTUCKY	\$162	\$397	\$217
LOUISIANA	\$125	\$397	\$192
MAINE	\$223	\$412	\$300
MARYLAND	\$211	\$397	\$284
MASSACHUSETTS	\$314	\$611	\$425
MICHIGAN	\$330	\$433	\$434
MINNESOTA	\$368	\$441	\$368
MISSISSIPPI	\$188	\$397	
MISSOURI	\$199	\$397	
MONTANA	\$193	\$397	\$265
NEBRASKA	\$280	\$534	\$375
NEVADA	\$194	\$487	
NEW HAMPSHIRE	\$292	\$413	\$292
NEW JERSEY	\$273	\$416	
NEW MEXICO	\$189	\$397	
NEW YORK	\$356	\$476	\$483
NORTH CAROLINA	\$167	\$397	\$225
NORTH DAKOTA	\$270	\$397	\$385
OHIO	\$216	\$397	
OKLAHOMA	\$218	\$555	\$292
OREGON	\$286	\$407	
PENNSYLVANIA	\$262	\$446	\$367
RHODE ISLAND	\$368	\$485	\$425
SOUTH CAROLINA	\$102	\$397	
SOUTH DAKOTA	\$280	\$412	
TENNESSEE	\$97	\$397	\$133
TEXAS	\$122	\$397	
UTAH	\$278	\$417	\$371
VERMONT	\$409	\$453	\$479
VIRGINIA	\$203	\$397	\$268
WASHINGTON	\$339	\$433	\$434
WEST VIRGINIA	\$164	\$397	\$225
WISCONSIN	\$377	\$558	\$542
WYOMING	\$280	\$437	

Source: Analysis of State Medicaid Program Characteristics, 1982. La Jolla Management Corporation, December 1982.

SSI recipients for Medicaid eligibility and their coverage of key optional groups. Exhibit 3-2 then presents selected income levels used by States in their AFDC, SSI and medically needy programs.

#### 3.1.1 Provision for the Medically Needy

Probably the most important eligibility decision States must make with regard to Medicaid is whether or not to cover the "medically needy." Instituting a medically needy program implies a considerable commitment for a State because it essentially removes the income eligibility ceiling for Medicaid for those with heavy medical expenses and thus substantially increases the population of potential eligibles. This happens because medically needy programs must deduct applicants' medical expenses from income in determining financial eligibility. As a result, categorically-related persons of all income levels may become eligible for Medicaid if their medical bills are large enough. Thirty States had medically needy programs in 1982, and the medically needy were about 13% of Medicaid recipients nationwide. They accounted for about 27% of overall Medicaid expenditures.

#### 3.1.2 Extent of Eligibility of SSI Cash Recipients

By law, a State must cover all AFDC cash recipients under its Medicaid program, but States do not have to cover all SSI recipients automatically. Instead, States have three options as to how they treat SSI recipients. First, under the "1634 agreement,"<sup>12</sup> States can elect to automatically cover all SSI recipients and not require them to make a special application for Medicaid. In effect, an application for SSI is also an application for Medicaid in these States. This is really the most "liberal" treatment of SSI recipients for Medicaid purposes. In 1982, 29 States chose this option. These States accounted for about 75% of SSI recipients nationwide.<sup>13</sup>

Second, States can elect to automatically cover all SSI recipients, but only if they complete a separate Medicaid application to the States. States generally choose this State determination option in order to retain complete control of the Medicaid eligibility determination process, rather than relinquish this responsibility to the Social Security Administration. With this option, a State can expect that probably not all SSI recipients will go to the effort of applying for Medicaid, thus curtailing

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<sup>12</sup>Refers to Section 1634 of the Social Security Act.

<sup>13</sup>Arizona's SSI population is excluded from all SSI calculations since the State did not have a comparable Medicaid program in 1982.

somewhat Medicaid expenditures for this group of recipients. Six States elected this option in 1982, affecting about 2.5% of SSI recipients nationwide.

Finally, States choosing the 209(b)<sup>14</sup> option may impose Medicaid eligibility criteria which are more restrictive than SSI criteria, so long as the criteria chosen were part of the State's approved Medicaid State plan in January 1972. 209(b) States may be more restrictive in defining blindness or disability, or more restrictive in their financial requirements for eligibility. Many States use this option to impose stricter transfer of assets or relatives' responsibility requirements than SSI. However, aged, blind and disabled Medicaid applicants must be allowed to spend-down in 209(b) States, regardless of whether or not the State has a medically needy program.<sup>15</sup> In spite of the spend-down requirements, the 209(b) option is perceived as a way for a State to reduce the number of categorically needy aged, blind and disabled enrollees for Medicaid. It is generally regarded as the most conservative SSI option. Fifteen States in 1982 used the 209(b) option for Medicaid coverage of aged, blind and disabled SSI recipients. About 22% of the SSI recipient population nationwide lived in these 209(b) States in 1982.<sup>16</sup>

### 3.1.3 Optional Coverage Groups

In addition to deciding the extent to which they will cover cash assistance recipients for Medicaid, States must decide whether or not to cover certain optional Medicaid groups. The two most comprehensive of the various optional coverage groups in terms of number of persons potentially affected and potential costs are low-income children under ages 18 to 21 in low-income families and families with unemployed parents. In electing to cover children in low-income families, States can elect to set the upper age limit from 18-21 years. However, the parents do not qualify for Medicaid. The AFDC and medically needy (if applicable) income standards apply in determining financial eligibility. This coverage group is often referred to as "Ribicoff kids" since Senator Ribicoff sponsored the Medicaid legislation establishing such children as an optional Medicaid group. They are also called "MA-21" children.

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<sup>14</sup>Named for Section 209(b) of the Social Security Amendment of 1972, which authorized this option.

<sup>15</sup>In spending-down, applicants must incur medical expenses at least equal to the amount by which their incomes exceed the adult assistance level.

<sup>16</sup>Of interest, the distribution of States among the three options for Medicaid treatment of SSI recipients has changed little since SSI was implemented in 1974.



These two optional groups of Ribicoff kids and families with unemployed parents open up Medicaid eligibility to children in two-parent poor families, a substantial portion of the poor population whose health needs otherwise would go unaddressed by Medicaid. Adding either of these groups closely follows adding a medically needy program in that it expands the population of potential eligibles and, thus, potentially increases program costs. States that elect these options are clearly identifying the coverage of low-income children as a priority in their Medicaid programs.

In 1982, 29 States included for Medicaid eligibility all children under ages 18-21<sup>17</sup> in low-income families. Twenty-four States covered families with unemployed parents under Medicaid.

Although there are many other optional coverage groups for States to choose among, none is of potentially the same magnitude of impact as the two groups just cited. The other optional groups either cover relatively small groups of Medicaid enrollees (for example, AFDC-related cases who would be eligible for AFDC if child care were paid from earnings) or they are used by all States making them of little use for analytic purposes (for example, coverage of the institutionalized by non-medically needy States).

#### 3.1.4 Payment and Income Levels

States are free to establish their own payment and income levels for both cash assistance and medical assistance within Federal guidelines. With the conversion to SSI in 1974, a national minimum payment level was established for the aged, blind, and disabled. States at their discretion may choose to provide optional supplementary payments to the SSI Federal minimum. However, no payment floor has ever been established for AFDC; setting the AFDC level is left totally to the discretion of States. For the most part, the AFDC levels chosen by States reflect their relative fiscal capabilities and dispositions toward assisting low-income families. State AFDC levels greatly affect the medically needy levels since Federal regulations specify that a State's medically needy level at a minimum must be as great as the highest payment level for any of the cash programs (by family size). However, Federal regulations also require that the medically needy level can be no greater than 133% of the AFDC level.

Not surprisingly, enormous variation exists with State payment and income levels for AFDC, SSI (with optional supplements) and the medically needy program. In 1982, Alabama had the lowest AFDC

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<sup>17</sup>23 out of 28 States in 1982 elected to set the upper age limit at age 21.



payment level. It used \$89 for its payment standard for a AFDC family of 2, while Alaska was the highest at \$508 for the same family. SSI levels ranged in 1982 from the Federal minimum of \$397 for an aged couple living independently (the level used by 23 States) to \$815 which California paid SSI aged couples with its optional supplement. Of the 30 States with medically needy programs, the income level ranged from \$133 in Tennessee for a family of 2 to \$542 in Wisconsin. Only 2 of the thirty medically needy States set their medically needy levels equal to the AFDC payment standard (for a 2-person case). Indeed, most of the medically needy States appear to set their income levels at the maximum amount allowable by Medicaid regulations -- 133% of the highest amount paid in AFDC by family size.

### 3.2 Potential Impact of Eligibility Decisions by States

The next question is -- what impact do these various key eligibility decisions appear to have on Medicaid enrollment and expenditures? For example, what difference does it make in terms of enrollee population and program costs to decide to implement a medically needy program or to require SSI recipients to make a separate application for Medicaid? What is the impact of coverage for the key optional groups? What difference do income levels make? To answer these questions, most of the analysis which follows draws upon 2082 annual operating data for Medicaid in FY 1982. AFDC and SSI operating data for 1982 are also utilized.

#### 3.2.1 Provision for Medically Needy

In the average medically needy State in 1982, the medically needy composed about 14% of the total Medicaid recipient population according to 2082 data (see Exhibit 3-3).<sup>18</sup> However, the range of experience among States was considerable. In 1982, Louisiana's medically needy were only 2% of the total recipient population, compared to North Dakota, where the medically needy were 30% of Medicaid recipients. There is no obvious explanation as to why States differ so in the size of the medically needy recipient

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<sup>18</sup>Two averages were calculated for this and subsequent exhibits to measure the experience of States along particular eligibility dimensions. Generally, in the discussion, the unweighted average is cited. Since the objective of this study was to analyze the likely impact of a particular eligibility decision for any single State, it seemed best to treat all States alike.

## Exhibit 3-3

Percentage of Medically Needy Recipients and Medically Needy Expenditures  
by State (with Medically Needy Programs) - 1982

	<u>% Medically Needy Recipients</u>	<u>% Medically Needy Expenditures</u>
ARKANSAS	10.2%	5.0%
CALIFORNIA	26.2%	36.1%
CONNECTICUT	25.1%	76.4%
DISTRICT OF COLUMBIA	11.6%	15.8%
HAWAII	16.8%	25.4%
ILLINOIS	13.3%	35.1%
KANSAS	22.1%	43.9%
KENTUCKY	25.5%	42.0%
LOUISIANA	2.3%	2.2%
MAINE	10.5%	5.1%
MARYLAND	17.6%	43.5%
MASSACHUSETTS	19.2%	51.2%
MICHIGAN	9.8%	35.7%
MINNESOTA	18.6%	30.4%
MONTANA	3.4%	3.1%
NEBRASKA	14.4%	43.5%
NEW HAMPSHIRE	7.6%	3.1%
NEW YORK	17.9%	51.2%
NORTH CAROLINA	15.7%	40.7%
NORTH DAKOTA	30.0%	59.7%
OKLAHOMA	9.5%	22.9%
PENNSYLVANIA	10.9%	20.9%
RHODE ISLAND	14.1%	12.1%
TENNESSEE	12.1%	36.5%
UTAH	19.1%	28.3%
VERMONT	5.7%	15.5%
VIRGINIA	17.1%	35.5%
WASHINGTON	6.3%	3.4%
WEST VIRGINIA	9.6%	7.5%
WISCONSIN	6.0%	6.3%
AVERAGE MEDICALLY NEEDY STATE*	14.3%	27.9%
ALL MEDICALLY NEEDY STATES*	17.1%	36.4%

\* Two calculations of averages were done for the medically needy states. The first average uses the sum of all the state percentages divided by the number of states. The second average uses the total Medicaid recipients or expenditures in the medically needy states and divides them by the total number of medically needy recipients or expenditures in those states. The first average weights all states alike, while the second average is weighted by the size of each state's Medicaid program.

Source: 2082 Data, 1982.

populations. Differences in administrative practices and varying levels of public awareness of eligibility criteria are hypothesized to be the major explanatory differences. Whatever the cause, this range makes it difficult to project exactly how much of a caseload increase a State is likely to experience if it adds a medically needy program.

Estimating the impact of a medically needy program is further complicated because many medically needy recipients are persons who would have been eligible for Medicaid even without a medically needy program. Many of the institutionalized in particular qualify as categorically needy/no cash recipients in non-medically needy States, while they would be considered to be medically needy in medically needy States. This inconsistency means that it is necessary to look at the categorically needy/no cash groups across States to better estimate the impact of the medically needy program.

Summative 2082 data for 1982 by the three maintenance status groups (i.e., categorically needy/cash, categorically needy/no cash, and medically needy) are shown below:

Distribution of Recipients by  
Maintenance Assistance Status

	<u>CN/\$</u>	<u>CN/No \$</u>	<u>MN</u>
Medically Needy States	77.7%	5.2%	17.1%
Non-Medically Needy States	83.6%	16.4%	-

These data show that States without medically needy programs report considerably higher proportions of categorically needy/no cash recipients than the medically needy States. These results suggest that adding a medically needy program may only increase a State's Medicaid population by about 6%, not the 14% that would seem likely if only medically needy data were considered. This estimate is based on comparing the relative size of the cash assistance population in medically needy and non-medically needy States.

Expenditure data for 1982 indicate that although the medically needy may be only a small proportion of recipients, in most medically needy States they cost significantly more than cash assistance recipients. On average among the 30 medically needy States, the medically needy account for 28% of expenditures even though they are only 14% of recipients. As shown in Exhibit 3-4, this means that medically needy per capita expenditures for medically needy States are about 3 times the size of categorically

Exhibit 3-4

Average Annual Expenditures Per Categorically Needy-Cash and Medically Needy  
Recipients By States (with Medically Needy Programs): 1982

	Categori- cally Needy-Cash	Medically Needy	Ratio of Medically Needy Per Capita Costs to Categorically Needy-Cash Per Capita Costs
ARKANSAS	\$ 959	\$ 658	0.69
CALIFORNIA	\$ 807	\$1261	1.56
CONNECTICUT	\$ 572	\$5524	9.66
DISTRICT OF COLUMBIA	\$1564	\$2249	1.44
HAWAII	\$ 749	\$1760	2.35
ILLINOIS	\$ 934	\$3274	3.51
KANSAS	\$1091	\$3006	2.76
KENTUCKY	\$ 715	\$1477	2.07
LOUISIANA	\$1099	\$1454	1.34
MAINE	\$ 776	\$ 623	0.80
MARYLAND	\$ 887	\$3190	3.60
MASSACHUSETTS	\$1076	\$4810	4.47
MICHIGAN	\$ 758	\$3790	5.00
MINNESOTA	\$1293	\$4033	3.12
MONTANA	\$ 933	\$1498	1.61
NEBRASKA	\$1182	\$5236	4.43
NEW HAMPSHIRE	\$ 543	\$ 795	1.46
NEW YORK	\$1571	\$7566	4.82
NORTH CAROLINA	\$ 867	\$3543	4.09
NORTH DAKOTA	\$1141	\$3538	3.10
OKLAHOMA	\$ 840	\$3558	4.24
PENNSYLVANIA	\$ 958	\$2739	2.86
RHODE ISLAND	\$ 898	\$1392	1.55
TENNESSEE	\$ 936	\$3866	4.13
UTAH	\$1176	\$2280	1.94
VERMONT	\$1001	\$3914	2.24
VIRGINIA	\$ 986	\$2911	2.95
WASHINGTON	\$ 988	\$ 798	0.81
WEST VIRGINIA	\$ 480	\$ 516	1.08
WISCONSIN	\$1087	\$1865	1.72
 AVERAGE MEDICALLY NEEDY STATE*	 \$ 962	 \$2771	 2.89
ALL MEDICALLY NEEDY STATES*	\$1003	\$3126	3.12
ALL STATES	\$ 976	\$3126	3.20

\* Two calculations of averages were done for the medically needy states. The first average uses the sum of all the state per capitas divided by the number of states. The second average uses the total Medicaid expenditures in the medically needy states divided by the total number of Medicaid recipients in those states. The first average weights all states alike, while the second average is weighted by the size of each state's Medicaid program.

Source: 2082 Data, 1982.



needy/cash per capita expenditures. In the average medically needy State, the annual per capita cost to a categorically needy/cash Medicaid recipient was \$962, compared to \$2,771 for a medically needy recipient.

On the other hand, the categorically needy/no cash recipients in non-medically needy States cost on average about 3.6 times as much as categorically needy/cash recipients. In 1982 for non-medically needy States, the cash assistance recipient per capita expenditures were \$907, while the average for non-cash recipients was \$3,280. The average for categorically needy/no cash recipients in medically needy States was \$2,963. These data in combination suggest that medically needy per capita expenditures in 1982 were somewhat less than those incurred by the categorically needy/no cash, but the difference was not great. The effect of having a medically needy program appears then to be primarily a greater number of recipients, with per capita expenditures only slightly less than the experience with the categorically needy/no cash.

Once again though, it should be remembered that the range among States was substantial. In 3 of the 30 medically needy States (Arkansas, Maine and Washington), medically needy recipients on average cost less than cash assistance recipients. At the high end, the medically needy in Connecticut averaged 10 times cash assistance recipients in per capita annual expenditures.

The actual distribution of the medically needy population in 1982 was: 27% aged, 12% disabled, 39% AFDC-related, and 22% "other". Looking at the overall population, about 23% of all aged Medicaid recipients nationwide in 1982 were classified as medically needy, compared to 12% of the disabled, 7% of AFDC-related children and 9% of AFDC-related adults. Thus, the program is most utilized by the aged.

On the other hand, the disabled are the most expensive medically needy group on a per capita basis. The average per capita expenditure for disabled medically needy recipients was \$6998 in 1982, compared to \$6132 for the aged medically needy, \$530 for AFDC-related children medically needy, and \$808 for AFDC-related adults medically needy.

These expenditure statistics just cited have to be interpreted with caution, however, because of differences in State practice regarding the classification of institutionalized Medicaid recipients and the lack of clear Federal instructions for the 2082 eligibility reporting groups. The problem is that some medically needy States automatically classify Medicaid nursing home recipients as medically needy if the recipients spend-down or contribute to the

cost of their nursing home care. In these States only the institutionalized who continue to receive SSI at up to \$25 per month for their personal needs are counted as categorically needy recipients. Other States classify the institutionalized according to whether or not they would be eligible for SSI if they were not institutionalized. In these States, for example, a person who received the full SSI benefit before institutionalization would continue to be coded as an SSI recipient (categorically needy) even though the person was no longer receiving SSI. An additional coding/reporting problem is the cash/no cash distinction for the categorically needy. Some States simply do not use this cash/no cash distinction in their reporting groups. Thus, they may incorrectly code categorically needy/no cash recipients as either categorically needy/cash or medically needy. All these complexities mean that the differences in State practice regarding classification of the institutionalized may considerably distort analysis of enrollment and expenditures patterns of the medically needy.

To remove the institutional distortions, recipient and expenditure counts from the 1982-2082 data were calculated subtracting out institutionalized recipients and institutional expenditures. The resulting data are shown in Exhibits 3-5 and 3-6.

In general, these data show that the non-institutional medically needy still cost more than non-institutional cash recipients, but the difference is not as great as when the institutional population and expenditures were included. For the average medically needy State, the per capita expenditure for a non-institutional medically needy recipient in 1982 averaged about \$1,414, compared to \$813 for a non-institutional cash recipient. Once again, the experience of non-medically needy States with the categorically needy/no cash is relevant. In 1982, non-institutional cash recipients in States without a medically needy program experienced per capita expenditures of \$687 annually compared to \$1,051 for the categorically needy/no cash. The multiple for the non-institutional medically needy is a little higher than the non-institutional categorically needy/no cash (1.74 vs. 1.5).

In summary, compared to cash recipients, it seems that the non-institutional medically needy cost about 1.75 times as much, and about three times as much if institutionalized recipients are included. These numbers vary somewhat from the experience of non-medically needy States with their categorically needy/no cash recipients, where the related multipliers are 1.5 (without the institutionalized) and 3.6 (with the institutionalized). These data suggest that a major difference of a medically needy program is that it brings in non-institutionalized recipients with greater health care costs than a State experiences with only the categorically needy/no cash.

## Exhibit 3-5

Percentage of Non-Institutional Medically Needy Recipients and Expenditures  
by States (with Medically Needy Programs) - 1982

	<u>% of Non-Institutional Recipients who are Medically Needy</u>	<u>% of Non-Institutional Expenditures Incurred by Medically Needy</u>
ARKANSAS	11.6%	11.7%
CALIFORNIA	24.6%	26.9%
CONNECTICUT	16.2%	37.3%
DISTRICT OF COLUMBIA	11.5%	18.8%
HAWAII	15.7%	19.7%
ILLINOIS	8.5%	16.9%
KANSAS	13.6%	20.9%
KENTUCKY	22.7%	20.6%
LOUISIANA	2.3%	4.6%
MAINE	11.3%	10.0%
MARYLAND	13.5%	18.7%
MASSACHUSETTS	14.7%	37.4%
MICHIGAN	6.1%	16.4%
MINNESOTA	14.4%	26.3%
MONTANA	3.7%	6.3%
NEBRASKA	4.0%	15.8%
NEW HAMPSHIRE	8.4%	9.6%
NEW YORK	12.6%	29.9%
NORTH CAROLINA	11.1%	19.0%
NORTH DAKOTA	19.7%	32.5%
OKLAHOMA	6.7%	18.7%
PENNSYLVANIA	10.0%	9.5%
RHODE ISLAND	15.2%	23.3%
TENNESSEE	6.5%	15.1%
UTAH	16.0%	23.7%
VERMONT	3.7%	8.7%
VIRGINIA	13.7%	18.9%
WASHINGTON	6.6%	6.8%
WEST VIRGINIA	9.8%	10.7%
WISCONSIN	4.9%	5.6%
AVERAGE MEDICALLY NEEDY STATE*	11.3%	18.0%
ALL MEDICALLY NEEDY STATES*	14.2%	23.0%

\* Two calculations of averages were done for the medically needy states. The first average uses the sum of all the state percentages divided by the number of states. The second average uses the total Medicaid recipients or expenditures in the medically needy states and divides them by the total number of medically needy recipients or expenditures in those states. The first average weights all states alike, while the second average is weighted by the size of each state's Medicaid program.

Source: 2082 Data, 1982.



## Exhibit 3-6

Average Annual Expenditures Per Categorically Needy-Cash and Medically Needy Recipients  
Excluding Institutional Care By State: 1982

	Categori- cally Needy-Cash	Medically Needy	Ratio of Medically Needy Per Capita Costs to Categorically Needy-Cash Per Capita Costs
ARKANSAS	\$ 666	\$ 656	0.98
CALIFORNIA	\$ 758	\$ 804	1.06
CONNECTICUT	\$ 754	\$1739	2.31
DISTRICT OF COLUMBIA	\$1416	\$2319	1.64
HAWAII	\$ 684	\$ 811	1.19
ILLINOIS	\$ 831	\$1609	1.94
KANSAS	\$ 840	\$1237	1.47
KENTUCKY	\$ 553	\$ 466	0.84
LOUISIANA	\$ 746	\$1480	1.98
MAINE	\$ 738	\$ 598	0.81
MARYLAND	\$ 743	\$1027	1.38
MASSACHUSETTS	\$1092	\$2769	2.54
MICHIGAN	\$ 702	\$1778	2.53
MINNESOTA	\$ 989	\$1807	1.83
MONTANA	\$ 857	\$1462	1.71
NEBRASKA	\$ 859	\$3369	3.92
NEW HAMPSHIRE	\$ 646	\$ 713	1.10
NEW YORK	\$1399	\$3394	2.43
NORTH CAROLINA	\$ 715	\$1222	1.71
NORTH DAKOTA	\$ 995	\$1347	1.35
OKLAHOMA	\$ 805	\$2230	2.77
PENNSYLVANIA	\$ 628	\$ 565	0.90
RHODE ISLAND	\$ 906	\$1391	1.54
TENNESSEE	\$ 727	\$1688	2.32
UTAH	\$ 829	\$1150	1.39
VERMONT	\$ 689	\$1604	2.33
VIRGINIA	\$ 768	\$1010	1.32
WASHINGTON	\$ 835	\$ 751	0.90
WEST VIRGINIA	\$ 458	\$ 486	1.06
WISCONSIN	\$ 771	\$ 934	1.21
AVERAGE MEDICALLY NEEDY STATE*	\$ 813	\$1414	1.74
ALL MEDICALLY NEEDY STATES*	\$ 768	\$1369	1.78

\* Two calculations of averages were done for the medically needy states. The first average uses the sum of all the state per capitas divided by the number of states. The second average uses the total amount of Medicaid expenditures in the medically needy states divided by the total number of Medicaid recipients in those states. The first average weights all states alike, while the second average is weighted by the size of each state's Medicaid program.

Source: 2082 Data, 1982.



### 3.2.2 Treatment of SSI Recipients

To assess the impact of selecting among the three options available to States for the Medicaid eligibility of SSI recipients, data were developed to depict both the enrollment and per capita expenditure experience in 1982 for States by the three options. It was hypothesized that States which elect to enroll SSI recipients automatically in the Medicaid program (1634 States) would have the highest ratios of Medicaid cash recipients to SSI recipients. With States that require SSI recipients to apply for Medicaid (State determination States), it was expected that the ratios would be somewhat lower. Finally, with 209(b) States which use more restrictive Medicaid eligibility criteria for SSI recipients, the lowest ratios were expected.

To test these hypotheses, ratios were constructed comparing FY 1982 Medicaid aged (and disabled) categorically needy/cash recipients to December 1981 SSI aged (and disabled) recipients. Unfortunately, data on the number of Medicaid recipients were annual data, while the SSI data were for only one month. As a result, the ratio of Medicaid recipients to SSI recipients often exceeded 1.0. This is not unexpected since caseload turnover would make the annual number of recipients larger than the recipient number for any one month.

The ratios, presented in Exhibits 3-7 and 3-8, indicate whether the proportion of SSI aged and disabled recipients on Medicaid varied by eligibility provisions.<sup>18</sup> Overall, it appears that there was no difference between 1634 and State determination States in the proportion of SSI aged recipients who received Medicaid as well. Thus, requiring a separate Medicaid application does not appear to reduce the number of SSI aged who use Medicaid services. However, there is a difference between 1634 and State determination States in the proportion of SSI disabled who received Medicaid as categorically needy/cash recipients. The State determination option appears to reduce by 30% the number of disabled categorically needy/cash Medicaid recipients for a State.

Electing the 209(b) option, not surprisingly, appears to reduce both the number of both aged and disabled categorically needy/cash Medicaid recipients. In 209(b) States, the proportion of SSI aged who are aged categorically needy/cash recipients was 20% lower than

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<sup>18</sup>The recipient ratios were developed by comparing the number of persons receiving SSI in each State in December 1981 to the Medicaid recipient population in that State for FY 1982. The HCFA 2082 reports and SSI Program Operating Statistics were the data sources. All the expenditure data are from the HCFA 2082.

Ratio of Number of 1982 Aged Cash Assistance Medicaid Recipients (CN-3) to  
Dec. 1981 Number of Aged SSI Recipients By State Option for Medicaid Treatment  
of SSI Recipients

<u>State</u>	<u>1634</u>	<u>State Determination</u>	<u>209(B) State</u>
ALABAMA	1.03	-	-
ALASKA	-	2.08	-
ARKANSAS	1.02	-	-
CALIFORNIA	1.22	-	-
COLORADO	-	1.37	-
CONNECTICUT	-	-	.48
DELAWARE	1.32	-	-
DIST COLUMBIA	1.80	-	-
FLORIDA	1.01	-	-
GEORGIA	1.04	-	-
HAWAII	-	-	1.02
IDAHO	-	.62	-
ILLINOIS	-	-	.80
INDIANA	-	-	.74
IOWA	1.19	-	-
KANSAS	-	1.19	-
KENTUCKY	1.10	-	-
LOUISIANA	1.17	-	-
MAINE	1.13	-	-
MARYLAND	1.13	-	-
MASSACHUSETTS	1.12	-	-
MICHIGAN	1.02	-	-
MINNESOTA	-	-	.95
MISSISSIPPI	-	-	.88
MISSOURI	-	-	.77
MONTANA	1.18	-	-
NEBRASKA	-	-	1.05
NEVADA	-	1.04	-
NEW HAMPSHIRE	-	-	.96
NEW JERSEY	1.03	-	-
NEW MEXICO	.96	-	-
NEW YORK	1.48	-	-
N CAROLINA	-	-	.75
N DAKOTA	-	-	.95
OHIO	-	-	.99
OKLAHOMA	-	-	1.29
OREGON	-	.63	-
PENNSYLVANIA	1.03	-	-
RHODE ISLAND	.89	-	-
S CAROLINA	1.04	-	-
S DAKOTA	1.10	-	-
TENNESSEE	1.07	-	-
TEXAS	1.18	-	-
UTAH	-	-	1.03
VERMONT	1.11	-	-
VIRGINIA	-	-	1.11
WASHINGTON	1.09	-	-
W VIRGINIA	1.42	-	-
WISCONSIN	.80	-	-
WYOMING	1.75	-	-
AVERAGE STATE RATIO*	1.15	1.15	.90
OVERALL STATE RATIO*	1.15	1.16	.92

\* Two calculations of averages were done for each SSI option. The first average uses the sum of all the state ratios divided by the number of states using each option. The second average uses the total number of aged cash assistance Medicaid recipients for the states using each option divided by the total number of aged SSI recipients for those states. The first average weights all states alike, while the second average is weighted by the size of each state's Medicaid and SSI recipient populations.

Source: 2082 Data, 1982; Social Security Bulletin, Annual Statistical Supplement, 1981, Table 161, p. 228; and Social Security Bulletin, June 1982, Table M-26, p. 40.

## Exhibit 3-8

Ratio of Number of 1982 Disabled Cash Assistance Medicaid Recipients  
to Dec. 1981 Number of Disabled SSI Recipients By State Option for  
Medicaid Treatment of SSI Recipients

<u>State</u>	<u>1982</u>	<u>State Determination</u>	<u>209(B) State</u>
ALABAMA	1.02	-	-
ALASKA	-	1.55	-
ARKANSAS	1.02	-	-
CALIFORNIA	1.19	-	-
COLORADO	-	.59	-
CONNECTICUT	-	-	.31
DELAWARE	.94	-	-
DIST COLUMBIA	.99	-	-
FLORIDA	1.03	-	-
GEORGIA	1.03	-	-
HAWAII	-	-	.86
IDAHO	-	.43	-
ILLINOIS	-	-	1.02
INDIANA	-	-	.54
IOWA	1.08	-	-
KANSAS	-	.86	-
KENTUCKY	1.02	-	-
LOUISIANA	.80	-	-
MAINE	1.03	-	-
MARYLAND	.91	-	-
MASSACHUSETTS	1.10	-	-
MICHIGAN	1.01	-	-
MINNESOTA	-	-	.92
MISSISSIPPI	-	-	.89
MISSOURI	-	-	.29
MONTANA	1.09	-	-
NEBRASKA	-	-	.80
NEVADA	-	1.26	-
NEW HAMPSHIRE	-	-	.99
NEW JERSEY	1.03	-	-
NEW MEXICO	1.04	-	-
NEW YORK	1.17	-	-
N CAROLINA	-	-	.51
N DAKOTA	-	-	.62
OHIO	-	-	.77
OKLAHOMA	-	-	.60
OREGON	-	.62	-
PENNSYLVANIA	1.00	-	-
RHODE ISLAND	2.25	-	-
S CAROLINA	1.01	-	-
S DAKOTA	1.07	-	-
TENNESSEE	.99	-	-
TEXAS	.83	-	-
UTAH	-	-	.75
VERMONT	.97	-	-
VIRGINIA	-	-	.81
WASHINGTON	.81	-	-
W VIRGINIA	.85	-	-
WISCONSIN	.97	-	-
WYOMING	.89	-	-
AVERAGE STATE RATIO*	1.05	.72	.72
OVERALL STATE RATIO*	1.04	.89	.71

\* Two calculations of averages were done for each SSI option. The first average uses the sum of all the state ratios divided by the number of states using each option. The second average uses the total number of disabled cash assistance Medicaid recipients for the states using each option divided by the total number of disabled SSI recipients for those states. The first average weights all states alike, while the second average is weighted by the size of each state's Medicaid and SSI recipient populations.

Source: 2082 Data, 1982; Social Security Bulletin, Annual Statistical Supplement, 1981, Table 163, p. 230; and Social Security Bulletin, June 1982, Table M-26, p.40.

the proportion seen in State determination and 1634 States. For the disabled, the impact is about the same as that seen with the State determination option, i.e., disabled Medicaid recipients (categorically needy/cash) are reduced by about 30%.

The cost data, presented in Exhibits 3-9 and 3-10, call into question how much money is saved by choosing the more restrictive eligibility options. For both the aged and the disabled, per capita Medicaid expenditures in 1982 were greater in State determination and 209(b) States than in 1634 States. For the aged, per capita expenditures were 13% greater in the average State determination State and 25% greater in the average 209(b) State. For the disabled, the average State determination State had per capita expenditures 75% greater, while the rate for the average 209(b) State was 16% greater. These results suggest that neither of these options may screen out the high utilizers in the SSI group. However, the use of per capita costs is only a limited measure of expenditures, and it can be argued that total costs in these States would have been even greater if all SSI recipients had been automatically enrolled in Medicaid. On the other hand, it is also possible that many SSI recipients in State determination and 209(b) States who are not on Medicaid do not receive sufficient routine preventive care, thus making their costs to Medicaid greater when they finally enroll. Of course, it could also be other factors which are affecting these cost data, such as reimbursement rates, service packages, etc. Nevertheless, these results do open to question the impact of restricting Medicaid coverage for aged SSI recipients. These data suggest that a few less enrollees do not necessarily cut expenditures even close to proportionally.

Unfortunately, there is such a high degree of dispersion in both the ratios and cost data among States for each of the three options for Medicaid treatment of SSI recipients that it is difficult to attribute the observed differences to the three options. The differences were not statistically significant. For example, in Wisconsin, a 1634 State, the Medicaid aged categorically needy/cash recipient caseload for all of 1982 was only 80% of the State's December 1981 aged SSI caseload. At the other extreme, in the District of Columbia (also a 1634 State), aged categorically needy/cash Medicaid recipients in 1982 were 180% of the SSI aged caseload.<sup>19</sup> On average, the 1982 Medicaid recipient caseloads for the aged categorically needy/cash in 1634 States were 15% greater than the December 1981 SSI aged caseload. The same degree of variances can be seen with the disabled and with the

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<sup>19</sup>There is a possibility that these extremes reflect some of the reporting problems States have in preparing their 2082 reports. For example, compiling an unduplicated count of annual Medicaid recipients is difficult for many States.



## Exhibit 3-9

1982 Per Capita Expenditure for Aged Cash Assistance Medicaid Recipients (CN-\$)  
by State Option for Treatment of SSI Recipients

<u>State</u>	<u>1982</u>	<u>State</u> <u>Determination</u>	<u>209(B)</u> <u>State</u>
ALABAMA	\$ 769	-	-
ALASKA	-	\$1985	-
ARKANSAS	\$1074	-	-
CALIFORNIA	\$ 799	-	-
COLORADO	-	\$2531	-
CONNECTICUT	-	-	\$1008
DELAWARE	\$2969	-	-
DIST COLUMBIA	\$4034	-	-
FLORIDA	\$1013	-	-
GEORGIA	\$1068	-	-
HAWAII	-	-	\$1781
IDAHO	-	\$ 786	-
ILLINOIS	-	-	\$2183
INDIANA	-	-	\$3662
IOWA	\$1608	-	-
KANSAS	-	\$2038	-
KENTUCKY	\$ 795	-	-
LOUISIANA	\$1351	-	-
MAINE	\$1269	-	-
MARYLAND	\$1845	-	-
MASSACHUSETTS	\$1736	-	-
MICHIGAN	\$1787	-	-
MINNESOTA	-	-	\$3862
MISSISSIPPI	-	-	\$ 845
MISSOURI	-	-	\$ 807
MONTANA	\$1762	-	-
NEBRASKA	-	-	\$2592
NEVADA	-	\$1226	-
NEW HAMPSHIRE	-	-	\$ 583
NEW JERSEY	\$2179	-	-
NEW MEXICO	\$ 895	-	-
NEW YORK	\$2844	-	-
N CAROLINA	-	-	\$1266
N DAKOTA	-	-	\$2645
OHIO	-	-	\$2519
OKLAHOMA	-	-	\$1685
OREGON	-	\$2255	-
PENNSYLVANIA	\$2530	-	-
RHODE ISLAND	\$3024	-	-
S CAROLINA	\$ 871	-	-
S DAKOTA	\$1849	-	-
TENNESSEE	\$ 980	-	-
TEXAS	\$1293	-	-
UTAH	-	-	\$2723
VERMONT	\$1604	-	-
VIRGINIA	-	-	\$1757
WASHINGTON	\$ 914	-	-
W VIRGINIA	\$ 827	-	-
WISCONSIN	\$1940	-	-
WYOMING	\$1728	-	-
AVERAGE STATE PER CAPITA*	\$1602	\$1803	\$1995
OVERALL STATE PER CAPITA*	\$1396	\$2241	\$1695

\* Two calculations of averages were done for each SSI option. The first average uses the sum of all the state per capitas divided by the number of states using each option. The second average uses the total amount of aged cash Medicaid expenditures for states with each SSI option divided by the total number of aged cash Medicaid recipients. The first average weights all states alike, while the second average is weighted by the size of each state's Medicaid program for the aged.

Source: 2082 Data, 1982; Social Security Bulletin, Annual Statistical Supplement, 1981, Table 161, p. 228; and Social Security Bulletin, June 1982, Table M-26, p. 40.

1982 Per Capita Expenditure for Disabled Cash Assistance Medicaid Recipients  
(CN-\$) by State Option for Treatment of SSI Recipients

<u>State</u>	<u>1634</u>	<u>State</u> <u>Determination</u>	<u>209(B)</u> <u>State</u>
ALABAMA	\$1557	-	-
ALASKA	-	\$3740	-
ARKANSAS	\$2176	-	-
CALIFORNIA	\$2087	-	-
COLORADO	-	\$6119	-
CONNECTICUT	-	-	\$1975
DELAWARE	\$3090	-	-
DIST COLUMBIA	\$4164	-	-
FLORIDA	\$1787	-	-
GEORGIA	\$2309	-	-
HAWAII	-	-	\$3476
IDAHO	-	\$1532	-
ILLINOIS	-	-	\$3537
INDIANA	-	-	\$5324
IOWA	\$4154	-	-
KANSAS	-	\$4860	-
KENTUCKY	\$1718	-	-
LOUISIANA	\$2832	-	-
MAINE	\$2214	-	-
MARYLAND	\$2818	-	-
MASSACHUSETTS	\$4276	-	-
MICHIGAN	\$3336	-	-
MINNESOTA	-	-	\$8362
MISSISSIPPI	-	-	\$1340
MISSOURI	-	-	\$1181
MONTANA	\$2972	-	-
NEBRASKA	-	-	\$4964
NEVADA	-	\$5916	-
NEW HAMPSHIRE	-	-	\$1634
NEW JERSEY	\$3140	-	-
NEW MEXICO	\$2277	-	-
NEW YORK	\$5308	-	-
N CAROLINA	-	-	\$2502
N DAKOTA	-	-	\$2780
OHIO	-	-	\$3565
OKLAHOMA	-	-	\$2480
OREGON	-	\$1419	-
PENNSYLVANIA	\$3466	-	-
RHODE ISLAND	\$1885	-	-
S CAROLINA	\$1635	-	-
S DAKOTA	\$4487	-	-
TENNESSEE	\$1845	-	-
TEXAS	\$3317	-	-
UTAH	-	-	\$6303
VERMONT	\$3996	-	-
VIRGINIA	-	-	\$2831
WASHINGTON	\$4246	-	-
W VIRGINIA	\$1012	-	-
WISCONSIN	\$4503	-	-
WYOMING	\$2827	-	-
AVERAGE STATE PER CAPITA*	\$2949	\$3931	\$3423
OVERALL STATE PER CAPITA*	\$2951	\$4194	\$3244

\* Two calculations of averages were done for each SSI option. The first average uses the sum of all the state per capitas divided by the number of states using each option. The second average uses the total amount of disabled cash Medicaid expenditures for states with each SSI option divided by the total number of disabled cash Medicaid recipients. The first average weights all states alike, while the second average is weighted by the size of each state's Medicaid program for the disabled.

Source: 2082 Data, 1982; Social Security Bulletin, Annual Statistical Supplement, 1981, Table 163, p. 230; and Social Security Bulletin, June 1982, Table M-26, p. 40.

other two SSI options. Substantial dispersion also exists in the per capita cost data.

### 3.2.3 Optional Group Coverage

#### MA-21 Children

The first optional coverage group of interest is children under age 18-21 in low-income families, or Ribicoff kids. As mentioned earlier, 29 States in 1982 elected to cover this group fully, i.e., all such children were potentially eligible for Medicaid. The other 21 States elected to cover only a subset or certain "reasonable classifications" of these children, such as foster care children, publicly subsidized adoptions, certain institutionalized children, and unborn children. Unfortunately, determining how many of these children are Medicaid recipients and what they cost is not straight-forward. The problem is that on the 2082 forms, there is no exactly corresponding reporting group for non-AFDC poor children. The seemingly appropriate reporting groups for these children would appear to be "Categorically Needy/No Cash Assistance-Other" and "Medically Needy-Other." In fact it seems likely that these two reporting groups would be devoted almost exclusively to non-AFDC children, because there are few other optional groups of any size that are not categorically related, i.e., AFDC-related, aged, blind or disabled.<sup>20</sup>

The 2082 data for 1982 show that the "Categorically Needy/No Cash-Other" and "Medically Needy-Other" groups nationwide are a fairly small proportion of Medicaid recipients and expenditures. These "other" groups make up about 3.8% of all recipients and 1.9% of overall expenditures. On a per capita basis, Medicaid recipients in the "other" groups are considerably more expensive than AFDC-related children, the most logical comparison group, as shown below.

	Nationwide Per Capita Medicaid <u>Expenditures - 1982</u>
AFDC Cash Assistance Children	\$373
AFDC/No Cash Children	\$323
AFDC-related Medically Needy Children	\$530
Categorically Needy/No Cash Other	\$792
Medically Needy-Other	\$739

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<sup>20</sup>USR&E's work for the Tape-to-Tape project on "mapping" State eligibility groups into the HCFA reporting groups used on the 2082 form suggested that States primarily use the "other" group for non-AFDC children. However, there have been reporting problems with this aspect of the 2082 form, so that this interpretation may not be true for all States.

These data indicate that any coverage of non-AFDC poor children by States probably implies per capita Medicaid expenditures 1 1/2 to 2 times greater than for AFDC-related children. There are several possible explanations for this greater cost. Many of these non-AFDC children are under State custody (child welfare children which includes both those in foster care and public adoption status) and come from family situations of neglect or abuse, which obviously affects their health status. There are also probably more disabled or handicapped children in the child welfare caseload than in AFDC. Finally, this non-AFDC group can be used to cover otherwise ineligible children in institutions, and it is well known that institutionalized costs are substantial.

The next question then is how much more does it cost for a State to cover all poor children under Medicaid as opposed to only reasonable classifications or subsets of them? To address this question, program data were compared for States with comprehensive MA-21 coverage (called MA-21 States) to States covering only subgroups of non-AFDC children (called limited child coverage States). The results are shown in Exhibits 3-11 and 3-12.

Not surprisingly, it appears that the "other" groups in MA-21 States are a greater proportion of the overall Medicaid recipient population than in the limited child coverage States. On average, "other" recipients are 3.9% of the overall Medicaid recipient caseload in MA-21 States, compared to 2.1% for the limited coverage States. Similarly, "other" expenditures in MA-21 States are about twice the size of "other" expenditures in the limited coverage States. These data suggest that comprehensive coverage of poor children for Medicaid eligibility purposes appears to about double the size and cost of the "other" group. Actually, it is surprising that the effect is so small. One would expect comprehensive Medicaid coverage of non-AFDC poor children to result in a much greater number of Medicaid recipients, if not proportionately greater costs. However, previous research has suggested that there is a very low participation rate for Medicaid by non-dependent low-income children in MA-21 States.<sup>21</sup> Probably the eligibility provisions for this part of Medicaid are not generally well known or understood, thus deterring participation. Some State

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<sup>21</sup>USR&E found evidence to this effect in a simulation model it developed for Massachusetts of potentially eligible spend-down recipients. This model estimated spend-downers in 1974 to have only a 1.5% participation rate for the Massachusetts Medicaid program. Most of the non-participants were MA-21 children. Evaluation of Medicaid Spend-Down, Volume 9, "Spend-Down Participation Rate," Urban Systems Research & Engineering, Inc., 1976, p.52.



Exhibit 3-11

Percentage of "Other" Categorically Needy-No Cash and Medically Needy  
Recipients and Expenditures by MA-21 States - 1982

<u>MA-21 States</u>	<u>% "Other" Recipients</u>	<u>% "Other" Expenditures</u>
ALABAMA	1.5%	0.5%
ARKANSAS	6.5%	2.9%
CALIFORNIA	6.9%	4.7%
CONNECTICUT	4.4%	3.8%
DISTRICT OF COLUMBIA	0.3%	0.5%
GEORGIA	0.6%	0.2%
HAWAII	0.8%	0.4%
IDAHO	2.3%	0.6%
IOWA	7.7%	4.2%
KENTUCKY	1.6%	1.1%
LOUISIANA	1.4%	0.8%
MASSACHUSETTS	3.8%	2.3%
MAINE	1.6%	0.9%
MARYLAND	*	*
MICHIGAN	0.9%	0.8%
MINNESOTA	6.9%	3.7%
MISSOURI	1.7%	1.0%
MONTANA	3.7%	1.7%
NORTH DAKOTA	6.3%	3.8%
NEW JERSEY	2.1%	4.5%
NEVADA	4.4%	1.5%
NEW YORK	10.0%	2.1%
OKLAHOMA	0.1%	0.0%
OREGON	10.3%	4.5%
PENNSYLVANIA	5.6%	1.4%
TENNESSEE	*	*
UTAH	8.9%	8.2%
VERMONT	2.0%	1.1%
WISCONSIN	2.6%	4.3%
<hr/>		
AVERAGE MA-21 STATE**	3.9%	2.3%
ALL MA-21 STATES**	5.2%	2.6%

\* These states were excluded from analysis because they did not report any recipients in the "other" group on the 2082 form. Although it is possible they did not have any recipients or expenditures for "other" cases, it seems more likely that they do not keep up with this type recipient in their reporting system.

\*\* Two calculations of averages were done for the MA-21 states. The first average uses the sum of all the state percentages divided by the number of states. The second uses the total number of "other" recipients or expenditures in MA-21 states and divides by the total number of Medicaid recipients or expenditures in these states. The first average weights all states alike, while the second average is weighted by the size of each state's Medicaid recipient population.

Source: 2082 data, 1982.

Exhibit 3-12

Percentage of "Other" Categorically Needy-No Cash and Medically Needy  
Recipients and Expenditures by Limited Child Coverage States - 1982

<u>Limited Child Coverage States</u>	<u>% "Other" Recipients</u>	<u>% "Other" Expenditures</u>
ARKANSAS	6.5%	0.2%
COLORADO	3.2%	3.2%
DELAWARE	5.7%	1.7%
FLORIDA	*	*
ILLINOIS	0.7%	0%
INDIANA	*	*
KANSAS	1.4%	3.4%
MISSISSIPPI	0.3%	0.1%
NORTH CAROLINA	1.4%	3.5%
NEBRASKA	3.9%	2.9%
NEW HAMPSHIRE	0.5%	0.1%
NEW MEXICO	1.8%	1.1%
OHIO	*	*
RHODE ISLAND	1.5%	0.4%
SOUTH CAROLINA	0.1%	0.1%
SOUTH DAKOTA	4.2%	1.0%
TEXAS	0.4%	0.1%
VIRGINIA	1.7%	1.0%
WASHINGTON	*	*
WEST VIRGINIA	*	*
WYOMING	0.2%	0%
<hr/>		
AVERAGE LIMITED CHILD COVERAGE STATE**	2.1%	1.2%
ALL LIMITED CHILD COVERAGE STATES**	1.3%	1.1%

\* These states were excluded from analysis because they did not report any recipients in the "other" group on the 2082 form. Although it is possible they did not have any recipients or expenditures for "other" cases, it seems more likely that they do not keep up with this type recipient in their reporting system.

\*\* Two calculations of averages were done for the limited child coverage states. The first average uses the sum of all the state percentages divided by the number of states. The second uses the total number of "other" recipients or expenditures in limited child coverage states and divides by the total number of Medicaid recipients or expenditure in these states. The first average weights all states alike, while the second average is weighted by the size of each state's Medicaid recipient population.

Source: 2082 data, 1982.

administrative practices may also serve to deter participation. As long as participation remains low, it seems as though this eligibility option is not a very expensive one for States. However, it should be noted that a couple of the large States report the "other" groups to be a considerably greater proportion of their Medicaid recipient caseloads. For example, "other" recipients make up 10.0% of New York's Medicaid population and 6.9% of California's population. Interestingly, in these States, "other" expenditures are proportionately much smaller, thus making the "other" recipient per capita costs look a lot more like AFDC children.

#### AFDC-U Families

Unfortunately, no Medicaid data were available which identified either the number of AFDC-U Medicaid recipients or their cost for the 24 States electing to cover this optional group. On the 2082 reporting forms, AFDC-U children and adults are merged with regular AFDC cases. Thus, this group really is non-identifiable in aggregate Medicaid data.<sup>22</sup>

AFDC program data are a source for determining at least the size of the AFDC-U cash assistance enrollee population for State Medicaid programs. State welfare programs separate regular AFDC from AFDC-U cases in their Federal reports to OFA/SSA. The most recently available OFA/SSA data (September 1981) indicate that AFDC-U recipients were just over 8% of AFDC cash recipients for the average AFDC-U State. Once again, the range in State experience was substantial. In Michigan, AFDC-U recipients were almost 18% of AFDC cash recipients compared to the District of Columbia, where they were only 1.5% of the AFDC caseload. Nevertheless, in over half of the AFDC-U States, AFDC-U recipients were at least 6.5% of the overall AFDC caseload.<sup>23</sup>

#### 3.2.4 Payment and Income Levels

Probably the most frequent area of eligibility-related decisionmaking by States involves increases in the payment and income levels for the AFDC, SSI and Medically Needy programs. The Federal SSI level is indexed annually, and many States also provide annual adjustments to their AFDC and SSI supplementation levels, as well as their Medically Needy levels. Several simulation models have been developed to project the impact of payment level changes on AFDC and SSI enrollment and costs. Yet, little analysis has been

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<sup>22</sup>MQC data and Tape-to-Tape data could potentially be used to look at this group, although it was not possible to do so for this project.

<sup>23</sup>Quarterly Public Assistance Statistics, Social Security Administration, DHHS, July-September 1981, Table 5, p. 6.

done as to what impact these changes have on State Medicaid programs. For example, how many new Medicaid recipients should a State expect if it raises its AFDC level by \$25 monthly? And will the new recipients use Medicaid benefits at about the same annual rate as current recipients? Unfortunately, currently available data do not permit the kinds of analysis necessary to answer these questions. No data set has yet provided information on differences in Medicaid utilization by AFDC and SSI payment levels and new vs. current recipients.

The only analysis possible with existing Medicaid data is a crude measure of the extent to which State Medicaid programs are covering poor people in a State. 2082 recipient statistics and census data on persons living below the poverty level (matched to the extent possible by category), indicate that higher income level States did enroll proportionately more Medicaid recipients in 1982, compared to the size of the State's poverty population. These results are shown in Exhibits 3-13 and 3-14. For example, States that supplement SSI had Medicaid aged cash recipient populations averaging 50.4% of the State aged poverty population, compared to 40.3% for States not choosing to supplement SSI income levels. Similarly, the top 10% of States according to their AFDC income levels covered an average of 116.4% of the State's poor children, compared to only 37.8% for the bottom 10%.<sup>24</sup>

These findings are fairly predictable. One would expect higher income levels to result in a proportionately greater number of Medicaid recipients relative to the number of poor.

### 3.3 An Eligibility Classification Scheme for States

The previous sections have shown that different individual eligibility policy decisions appear to have an impact on State Medicaid enrollment and expenditures. However, it can be overwhelming and somewhat distorting to look only at the many individual components of State eligibility policies. Such a piecemeal focus makes it difficult to understand how States compare to each other overall with regard to eligibility.

Accordingly, it seemed worthwhile to investigate in a broader fashion whether or not differences among States in terms of program enrollment and cost appear correlated with overall eligibility policies. To test this hypothesis, USR&E developed a six-tiered classification scheme which groups States according to the

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<sup>24</sup>However, a test of rank order correlation did not show a positive correlation for the aged (Exhibit 3-13). For children (Exhibit 3-14), a fairly strong positive correlation was found to exist between the size of AFDC payment levels and the number of AFDC children relative to the number of children living below the poverty level for States.



## Exhibit 3-13

Comparison of Medicaid Recipient Statistics for the Aged  
to Poverty Level Data by State

<u>States (in Descending Order by Aged Cash Payment Level)</u>	<u>Ratio of Number of Aged Cash Assistance Medicaid Recipients (1982) to Number of Persons over Age 65 Living Below Poverty Level (1979)**</u>
CALIFORNIA	1.95
COLORADO	0.97
ARKANSAS	1.78
MASSACHUSETTS	0.99
WISCONSIN	0.44
OKLAHOMA	0.56
NEBRASKA	0.19
CONNECTICUT	0.17
NEVADA	0.52
RHODE ISLAND	0.33
NEW YORK	0.79
ILLINOIS	0.20
VERMONT	0.50
PENNSYLVANIA	0.31
IDAHO	0.12
MINNESOTA	0.18
WYOMING	0.24
MICHIGAN	0.33
WASHINGTON	0.33
DISTRICT OF COLUMBIA	0.54
HAWAII	0.63
UTAH	0.19
NEW JERSEY	0.40
NEW HAMPSHIRE	0.15
SOUTH DAKOTA	0.23
MAINE	0.46
OREGON	0.15
ALABAMA*	0.63
ARKANSAS*	0.48
DELAWARE*	0.40
FLORIDA*	0.40
GEORGIA*	0.55
INDIANA*	0.14
IOWA*	0.25
KANSAS*	0.21
KENTUCKY*	0.48
LOUISIANA*	0.67
MARYLAND*	0.36
MISSISSIPPI*	0.54
MISSOURI*	0.29
MONTANA*	0.22
NEW MEXICO*	0.40
NORTH CAROLINA*	0.34
NORTH DAKOTA*	0.22
OHIO*	0.22
SOUTH CAROLINA*	0.46
TENNESSEE*	0.48
TEXAS*	0.60
VIRGINIA*	0.44
WEST VIRGINIA*	0.41

\* States that did not supplement Federal minimum for SSI.

\*\*Census data on aged poverty rates are for 1979 and have not been adjusted to include an estimate of those receiving Medicaid who were not poor.

Source: SSI Aged Payment Levels: La Jolla Management Corporation, Analysis of State Medicaid Program Characteristics, 1982; Aged Poverty Rates: Summary Characteristics for Government Units and SMSAs, 1980 Census of Population and Housing, U.S. Dept. of Commerce, Bureau of the Census.

## Exhibit 3-14

Comparison of Medicaid Recipient Statistics for AFDC Children-Cash  
to Poverty Level Data by State

States (in Descending Order by AFDC Cash Payment Level)	Ratio of Number of AFDC Children-Cash Assistance Medicaid Recipients (1982) to Number of Children Living Below Poverty Level (1979)*
ARKANSAS	0.81
VERMONT	0.97
CALIFORNIA	1.25
HAWAII	1.43
WISCONSIN	1.36
RHODE ISLAND	1.36
MINNESOTA	0.93
NEW YORK	1.10
CONNECTICUT	0.99
WASHINGTON	0.89
MICHIGAN	1.75
MASSACHUSETTS	1.36
IOWA	0.80
NEW HAMPSHIRE	0.63
OREGON	0.78
NEBRASKA	0.58
SOUTH DAKOTA	0.32
WYOMING	0.52
UTAH	0.41
NEW JERSEY	1.15
KANSAS	0.95
NORTH DAKOTA	0.38
PENNSYLVANIA	1.08
ILLINOIS	1.19
COLORADO	0.62
IDAHO	0.44
DISTRICT OF COLUMBIA	1.27
MAINE	0.92
INDIANA	0.50
OKLAHOMA	0.67
OHIO	1.09
MARYLAND	1.02
VIRGINIA	0.60
MISSOURI	0.66
DELAWARE	0.92
NEVADA	0.50
MONTANA	0.59
NEW MEXICO	0.45
MISSISSIPPI	0.51
NORTH CAROLINA	0.45
WEST VIRGINIA	0.66
KENTUCKY	0.50
GEORGIA	0.49
FLORIDA	0.47
ARKANSAS	0.37
LOUISIANA	0.24
TEXAS	0.29
SOUTH CAROLINA	0.49
TENNESSEE	0.48
ALABAMA	0.40

\* Census data on children poverty rates are for 1979 and have not been adjusted to include an estimate of those receiving Medicaid who were not poor.

Source: AFDC Payment Levels: La Jolla Management Corporation, Analysis of State Medicaid Program Characteristics, 1982; Children Poverty Rates: Summary Characteristics for Government Units and SMSAs, 1980 Census of Population and Housing, U.S. Dept. of Commerce, Bureau of the Census.

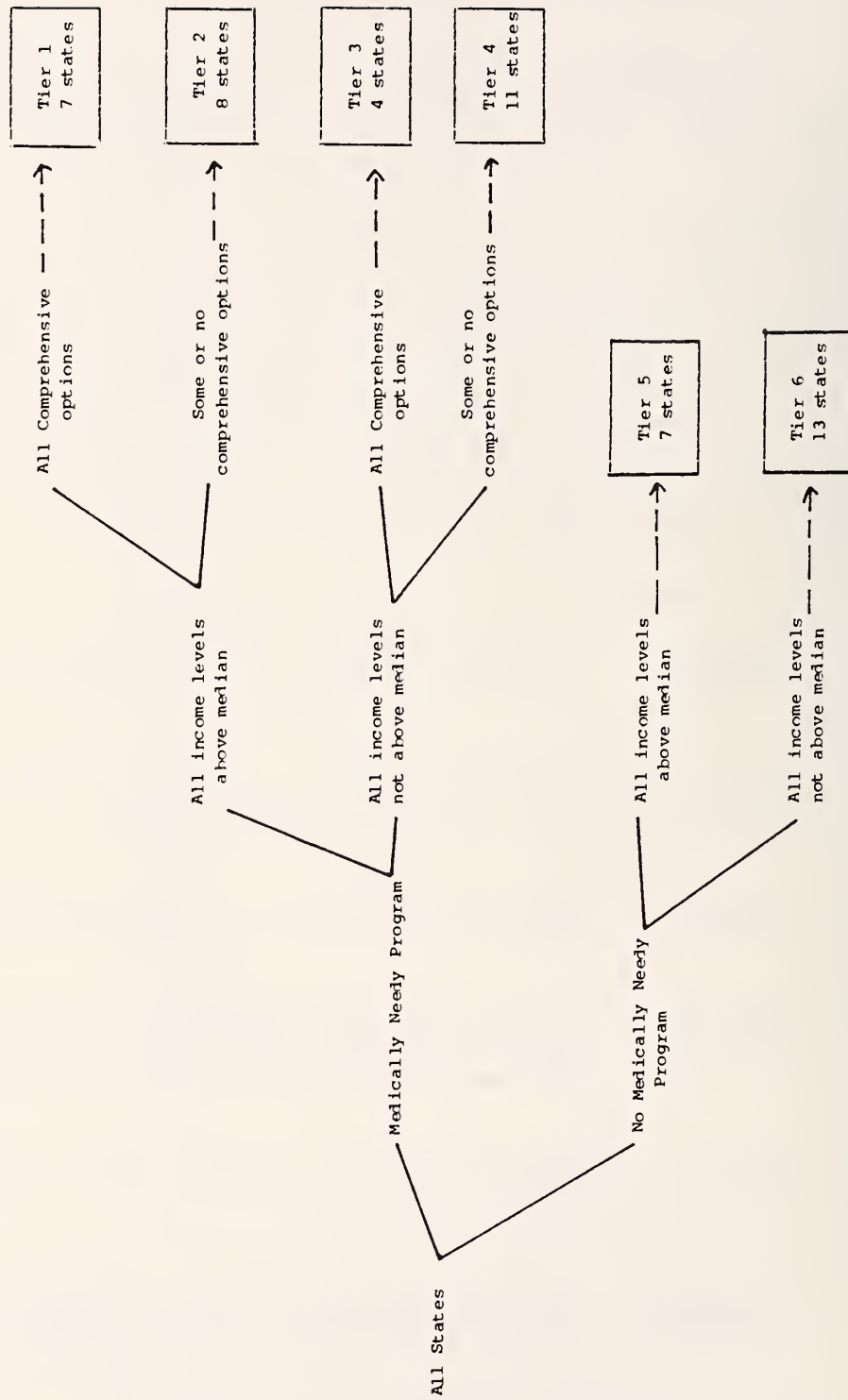
comprehensiveness of their Medicaid eligibility provisions. Comprehensiveness was judged by looking cumulatively at State decisions in the four key areas of eligibility policy discussed in Sections 3.1 and 3.2. Since the four policy areas are not felt to be of equal importance, an ordering was imposed. First, the classification scheme considered whether or not a State had a Medically Needy program. Since a Medically Needy program hypothetically removes all income barriers to Medicaid eligibility, it was felt to be the most important determinant to the comprehensiveness of a State's eligibility provisions. Second, the income levels (SSI and AFDC plus medically needy where appropriate) used by a State were reviewed, to determine whether they were above or below the median State level for each program. This step assumes that States with all income levels above the median are more comprehensive. Third, for medically needy States, a determination was made as to whether or not each State had elected the most "liberal" of the other eligibility options, i.e., did the State automatically enroll SSI recipients in Medicaid and did the State include both the AFDC-U and MA-21 optional groups in its coverage. Exhibit 3-15 depicts the decision tree for placing States in the classification scheme.

The 6 resulting tiers are constituted as follows:

- Tier 1 - California, Massachusetts, Michigan, New York,  
(7 States) Pennsylvania, Vermont, and Wisconsin.
  
- Tier 2 - Connecticut, Hawaii, Illinois, Kansas, Nebraska,  
(8 States) Rhode Island, Utah and Washington
  
- Tier 3 - District of Columbia, Kentucky, Maryland, and  
(4 States) Maine
  
- Tier 4 - Arkansas, Louisiana, Minnesota, Montana, New  
(11 States) Hampshire, North Carolina, North Dakota,  
Oklahoma, Tennessee, Virginia and West Virginia
  
- Tier 5 - Alaska, Colorado, Iowa, New Jersey, Oregon, South  
(7 States) Dakota and Wyoming
  
- Tier 6 - Alabama, Delaware, Florida, Georgia, Idaho,  
(13 States) Indiana, Mississippi, Missouri, New Mexico,  
Nevada, Ohio, South Carolina and Texas.

Exhibit 3-15

Comparison of Medicaid Per Capita Expenditures for States with Income Levels Above and Below the Median





With this scheme, Tier 1 States are hypothesized to be the most comprehensive or liberal in their eligibility policies. Thus, one would expect Tier 1 States to have the greatest "capture" rate in terms of the proportion of Medicaid recipients relative to the States' poor population. The other tiers are hypothesized to be increasingly less comprehensive with Tier 6 having the most restrictive eligibility policies.

Exhibit 3-16 presents data that generally confirm this hypothesis. Although Tier 1 States had only 30% of the nation's poor (as measured by the poverty level in 1979<sup>25</sup>), they accounted for almost half of all Medicaid recipients in 1982. At the other extreme, Tier 6 States had 32% of the U.S. population living below the poverty level, but they were responsible for only 21% of all Medicaid recipients. The classification scheme is much weaker for the intervening tiers. A gradual decline occurs in the number of Medicaid recipients relative to the poor population in Tiers 2 through 4. Only Tier 5 breaks the pattern. Tier 5 States in 1982 had 6% of Medicaid recipients and about 6% of the U.S. poor, whereas Tier 4 States had only 12% of Medicaid recipients but 17% of the poor. This would suggest that higher income levels are a more powerful determinant of the size of the Medicaid recipient population than the presence of a medically needy program with low income levels and limited or no key optional groups.

Thus, in the more liberal States with regard to eligibility policies, the States are more likely to have a Medicaid recipient population greater than or equal to the size of the State's poor population. The most restrictive States, on the other hand, have larger poverty populations than their Medicaid recipient populations. It should be recognized that there cannot be an exact match between Medicaid recipients and the poor in a State since Medicaid categorical requirements exclude many of the poor from Medicaid eligibility, even in the most liberal States (for example, single non-disabled adults generally cannot qualify for Medicaid in any State). The comparison with the poverty population is used as a proxy measure to estimate the number of poor people in a State who might potentially need publicly financed health care services.

Exhibit 3-17 shows that even though the "capture" rate varied among the tiers in a somewhat predictable manner, the per capita expenditures did not follow any logical pattern. Tier 1 and Tier 5

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<sup>25</sup>Unfortunately, the most recently available State level poverty data are for 1979. Since the size of the poverty population has been increasing in the early 1980s, it would be a much better test of the classification scheme if 1982 poverty data were available.

Exhibit 3-16

Distribution of Overall Medicaid Recipients and U.S. Poverty  
Population by Eligibility Classification Scheme

	<u>% of Overall U.S. Medicaid Recipient Population - 1982</u>	<u>% of Overall U.S. Population Living Below Poverty Level - 1979*</u>
Tier 1	46.9%	29.5%
Tier 2	9.9%	9.5%
Tier 3	4.5%	4.7%
Tier 4	12.2%	17.1%
Tier 5	5.9%	6.3%
Tier 6	20.5%	31.7%

\* Does not sum to 100% because Arizona not included.

Source: 2082 Data, 1982; Statistical Abstract of U.S. 1982-1983,  
Table 732, p. 443.

Exhibit 3-17

Per Capita Medicaid Expenditures by Cash Assistance Status and by Eligibility Classification Scheme

		<u>Categorically Needy-Cash</u>	<u>Categorically Needy- No Cash</u>	<u>Medically Needy</u>	<u>Categorically Needy- No Cash and Medically Needy</u>
Tier 1	Average State*	\$1,037	**	\$3,706	\$3,610
	Average All States*	\$1,044	\$2,340	\$3,214	\$3,053
Tier 2	Average State*	\$949	**	\$2,909	\$3,312
	Average All States*	\$924	\$3,143	\$3,297	\$3,255
Tier 3	Average State*	\$986	**	\$1,885	\$2,234
	Average All States*	\$894	\$2,304	\$2,000	\$2,061
Tier 4	Average State*	\$916	\$3,846	\$2,397	\$3,407
	Average All States*	\$958	\$4,165	\$3,093	\$3,547
Tier 5	Average State*	\$1,058	\$4,366	-	-
	Average All States*	\$963	\$3,270	-	-
Tier 6	Average State*	\$888	\$3,431	-	-
	Average All States*	\$891	\$3,284	-	-

\* Two calculations of averages were done. The first average uses the sum of all the state per capitas in each grouping divided by the number of states. The second average uses the total amount of Medicaid expenditures for states in each grouping divided by the total number of Medicaid recipients. The first average weights all states alike, while the second average is weighted by the size of each state's Medicaid program.

\*\* Some states did not report completely for all the categorically needy/no cash groups. Average state calculations were not done for tiers in which this occurred.

Source: 2082 Data, 1982.

States spent the most per capita for cash assistance recipients, but there was not a wide disparity with the other tiers. More variation occurred with the non-cash groups. For non-cash recipients, Tiers 1, 2, 4, and 6 were fairly close to each other, but Tiers 3 and 5 broke the pattern. The per capita costs for the categorically needy/no cash and the medically needy in the average Tier 3 State were considerably less than the costs of States in the other tiers, while Tier 5 States were considerably higher on average. There is no obvious explanation for this difference.

#### 3.4 Analysis of Person-Based Eligibility Data for Michigan and New York

The Tape-to-Tape data base which will include person-based enrollment, utilization and cost data for five States (New York, Michigan, California, Tennessee and Georgia) for 1980, 1981 and 1982 will eventually be a major source for eligibility-related research. However, for this short-term evaluation effort, only initial results were available from the Tape-to-Tape project. "Early Returns Tables" for Michigan and New York in 1980 and 1981 were completed just before this report went to press. The Early Returns Tables are a standard series of about 200 cross-tabulations on enrollment, service utilization and expenditures to be completed for each study year in each Tape-to-Tape State. Though extensive analysis could not be undertaken of the Michigan and New York data for this report due to time constraints, a quick review of the data for 1981 revealed several important results with regard to eligibility concerns. These are summarized below.

The reader is reminded that both Michigan and New York are Tier 1 States with regard to eligibility policy. They both have medically needy programs and relatively high income levels for both cash assistance and the medically needy. They both automatically enroll all SSI recipients in their Medicaid programs. Finally, they both have elected to cover AFDC-U and "Ribicoff kids" for Medicaid eligibility. The comprehensiveness of the Medicaid programs in the two States should be kept in mind in reviewing the data.

Although the Michigan Tape-to-Tape data are fairly complete, there are limitations to the New York data which complicate the analysis of the early returns results. First, New York was phasing in its MMIS system during 1981; therefore, a few upstate counties are not included in the data for the entire year. Second, claims and enrollee data for some large State-operated facilities in New York are not included in the 1981 data. Third, neither are personal care services for New York City included in the 1981 data. These missing data do not significantly impact the Tape to Tape enrollment data for New York, but the expenditure totals are lower than they should be. Thus, expenditure data for New York should be interpreted with caution.



#### 3.4.1 Enrollee/Recipient Ratios

One shortcoming of the 2082 data base is that it only reports on the number of Medicaid recipients in each State, i.e., those Medicaid enrollees who utilized services during the year. As a result, analysts have not known how many persons are enrolled in the Medicaid program nationwide, nor have they been able to estimate the probability of Medicaid utilization by various eligibility groups. Fortunately, the Tape-to-Tape data base includes data on both enrollees and recipients, and thus can address these questions.

1981 Tape-to-Tape results for Michigan and New York show that the great majority of Medicaid enrollees are also Medicaid recipients. Overall, 79% of New York enrollees and 80% of Michigan enrollees utilized at least one Medicaid service during 1981, as shown in Exhibit 3-18.<sup>26</sup>

These rates varied considerably by cash assistance status and eligibility group, with some differences in patterns between the two States. In both New York and Michigan, the aged had the highest reciprocity rates (81% and 90%), with the medically needy aged higher than the cash assistance aged. The reciprocity rates for the disabled were 79% in New York and 90% in Michigan. AFDC-related children had the lowest reciprocity rates -- 79% in New York and 77% in Michigan. AFDC-related adults had rates of 80% (New York) and 81% (Michigan). For AFDC-related adults and children, higher reciprocity rates were reported for cash assistance enrollees than medically needy enrollees.

#### 3.4.2 Length of Enrollment

A second shortcoming of the 2082 data is that it does not include any information on length of enrollment or turnover by eligibility group and cash assistance status. Since the Tape-to-Tape data base tracks enrollment on a monthly basis for all enrollees, it allows the calculation of length of enrollment statistics. Exhibit 3-19 presents in the first column a distribution of enrollees (persons ever enrolled) in both States by cash assistance States and eligibility groups. Then in the second column it shows the distribution by person-years of enrollment. Person-years of enrollment is a new enrollment measure developed in the Tape-to-Tape project to depict the effect of length of enrollment differences among groups and thus to reflect the actual

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<sup>26</sup>In this example, as in others to follow, the reader should keep in mind that New York's data may be affected by the fact that the MMIS was not fully implemented throughout the State in 1982.

Exhibit 3-18

Percent of Enrollees Receiving Services; New York and Michigan, 1981

Cash Assistance Status	Recipients as a percent of enrollees									
	Eligibility Group									
	SSI				AFDC					
	Total		Aged		Disabled		Children		Adults	
	NY	MI	NY	MI	NY	MI	NY	MI	NY	MI
Categorically Needy/ Receiving Cash	81.3%	80.0%	77.6%	86.2%	80.5%	88.6%	81.2%	77.3%	83.6%	82.4%
Medically Needy	72.1	85.4	84.8	92.2	79.1	92.3	58.8	64.1	60.8	69.4
Total Medicaid	78.5	80.1	81.1	89.6	78.9	89.7	78.9	76.6	80.4	81.3

Source: Table E-1-A-1, Tape-to-Tape Early Returns Data, New York and Michigan, 1981.

## Exhibit 3-19

Michigan and New York Medicaid, 1981Percent Distribution of Persons Ever Enrolled and Person-Years of Enrollment  
by Cash Assistance Status and Eligibility Group

	<u>Persons Ever Enrolled</u>		<u>Person-Years of Enrollment</u>	
	NY	MI	NY	MI
Categorically Needy/ Receiving Cash	77.3%	86.9%	81.9%	89.1%
Aged	7.6	3.1	8.5	3.7
Disabled	10.9	6.2	12.6	7.6
AFDC Child	40.4	51.0	42.2	51.2
AFDC Adult	18.2	26.4	18.4	26.5
Medically Needy	19.3	9.5	15.1	8.2
Aged	7.2	4.2	6.5	4.0
Disabled	2.3	2.5	1.9	2.4
AFDC Child	4.6	1.0	3.1	0.7
AFDC Adult	3.0	0.9	1.9	0.6
Total Medicaid	100.0	100.0	100.0	100.0
Aged	14.9	7.5	15.0	8.0
Disabled	13.2	9.0	14.5	10.3
AFDC Child	45.0	53.8	45.3	53.0
AFDC Adult	21.2	28.7	20.3	28.0
	n=2,047,956	n=1,164,763	n=1,493,524	n=899,138

Source: Tables E-1-A-1 and E-2-A-1, Tape-to-Tape Early Returns Data, New York and Michigan, 1981.

exposure of the population at risk. The person-year measure is calculated by summing actual days of enrollment for all individuals in each eligibility group and then dividing the sum by 365 to compute person-years of enrollment. Whereas the number of enrollees (persons ever enrolled) counts each person equally, whether enrolled for only a few days or the entire year, person-years of enrollment weights the enrollee count by length of enrollment or turnover.

The person-year of enrollment data in Exhibit 3-19 show that the medically needy in both States had more turnover than the categorically needy/receiving cash. In New York, the medically needy were 19.3% of enrollees, but only 15.1% of person-years of enrollment. In Michigan, they were 9.5% of enrollees, but only 8.2% of person-years of enrollment. Among the eligibility groups, the disabled and the aged showed considerably less turnover than the AFDC-related enrollees. These differences are not surprising; nevertheless, it is useful to have them documented.

Another way of looking at these data is to calculate mean length of enrollment figures for each group for 1981.<sup>27</sup> The results are shown in Exhibit 3-20 for Michigan and New York. Since not all counties were in New York's MMIS for all of 1981, the calculations for New York are subject to error.

The Michigan data show that overall Medicaid enrollees averaged about 9.3 months of enrollment throughout the year. The overall average in New York was 8.8 months. In both States, the disabled had the longest enrollment duration--10.6 months in Michigan and 9.7 months in New York; the aged followed at second. Probably the major reason that the average for the aged is lower than that of the disabled is the higher mortality rate among the aged. Both AFDC-related children and adults averaged about 9 months length of enrollment for 1981 in Michigan with 8.4 months for children and 8.8 months for adults in New York. With regard to cash assistance status, the categorically needy/cash enrollees showed longer enrollment than the medically needy in Michigan. They averaged 9.5 months enrollment, compared to 8.1 months for the medically needy. In New York, the difference was even greater. Cash enrollees averaged 9.3 months, compared to 6.9 months for the medically needy.

#### 3.4.3 Expenditure and Utilization Patterns

Because the 2082 data do not contain enrollee counts or information on the length of enrollment by eligibility group, they

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<sup>27</sup>To calculate the mean length of enrollment for the year, the total person years of enrollment are divided by the total number of enrollees, then the resulting percentage is multiplied by 12 (months).



Exhibit 3-20

Mean Length of Enrollment by Cash Assistance Status and Eligibility  
Group: Michigan and New York, 1981

Cash Assistance Status/ Eligibility Group	Mean Length of Enrollment in 1981 (months)	
	<u>NY</u>	<u>MI</u>
Categorically Needy/Receiving Cash	9.3	9.5
Aged	9.7	11.1
Disabled	10.1	11.3
AFDC Child	9.2	9.3
AFDC Adult	8.8	9.3
Medically Needy	6.9	8.1
Aged	7.9	8.9
Disabled	7.3	8.9
AFDC Child	5.9	6.0
AFDC Adult	5.6	5.7
Total Medicaid	8.8	9.3
Aged	8.8	9.8
Disabled	9.7	10.6
AFDC Child	8.8	9.1
AFDC Adult	8.4	9.0

Source: Tables E-1-A-1 and E-2-A-1, Tape-to-Tape Early Returns Data,  
New York and Michigan, 1981.

can only be used to calculate annual recipient per capita expenditure statistics. The richness of the Tape-to-Tape data allow analysts to look at per capita expenditures in several alternative ways. These alternative measures of per capita costs can be used to support much more precise estimates of the cost impacts of Medicaid eligibility changes.

Exhibit 3-21 shows three different per capita expenditure calculations. In the first column, Exhibit 3-21 shows for each State in 1981 the cost per recipient by cash assistance status and eligibility group. This is the same measure that can be calculated from 2082 data. Column 2 shows the per capita cost per enrollee. These statistics are not weighted by the different reciprocity rates by group. Finally, the third column shows the average cost per person year of enrollment. This measure factors in differences among groups in length of enrollment.

Using Michigan's AFDC-related medically needy adults as an example, the per recipient cost in 1981 was \$1172 annually. Since 31% of enrollees in this group did not use any Medicaid services during the year, the per enrollee annual cost was substantially less -- \$813. However, most medically needy AFDC adults were only on the program an average of 5.7 months in 1981. Thus, the full year cost of having a medically needy AFDC enrollee on Michigan's program in 1981 was \$1718, over double the size of the per enrollee cost.

For New York, dramatic differences can be seen with the aged medically needy. The per capita cost of an aged medically needy recipient was \$8900 in 1981. The \$7545 cost per enrollee was less because only 85% of this group were service recipients during 1981. Since the aged medically only average 7.9 months of enrollment during the year, the full year cost of having a medically needy aged person in the program in 1981 was \$11,475.

The Tape-to-Tape data also allow a fine-tuned analysis of differences in utilization patterns among the eligibility groups. Exhibits 3-22 and 3-23 depict some of the utilization data for Michigan which are generated in the Early Returns Tables. These utilization data can be used to estimate the impacts of service policy changes for the various eligibility groups.

Exhibit 3-22 shows that medically needy enrollees had the highest service reciprocity rates for inpatient hospital, long-term care and drug services, while cash enrollees were more likely to have used ambulatory care and dental services. Most of the long-term care utilization occurred among the medically needy, while there was more even distribution of reciprocity rates between the categorically and medically needy for other services.

Exhibit 3-21

Expenditures Per Recipient, Per Enrollee, and Per Person-Year of  
Enrollment: Michigan and New York, 1981

	Per Recipient		Per Enrollee		Per Person Year of Enrollment	
	<u>MI</u>	<u>NY</u>	<u>MI</u>	<u>NY</u>	<u>MI</u>	<u>NY</u>
Categorically Needy/						
Receiving Cash	\$840	\$1035	\$672	\$715	\$849	\$1088
Aged	1305	1939	1125	1504	1218	1856
Disabled	3177	2748	2640	2219	2801	2618
AFDC Child	411	468	317	379	410	498
AFDC Adult	985	914	837	764	1082	1038
Medically Needy	3689	5144	3152	3707	4682	6478
Aged	4392	8900	4048	7545	5466	11475
Disabled	4782	6665	4413	5273	5947	8625
AFDC Child	456	768	292	452	586	922
AFDC Adult	1172	1025	813	623	1718	1343
Total Medicaid	1128	1752	904	1376	1171	1887
Aged	3072	5478	2754	4441	3357	6034
Disabled	3474	3413	3116	2738	3526	3405
AFDC Child	409	491	313	387	412	527
AFDC Adult	1012	926	823	744	1096	1067

Source: Tables E-1-A-1, X-4-G-1, X-5-G-1, Tape-to-Tape Early Returns Data, Michigan and New York, 1981.

Exhibit 3-22

Percent of Enrollees Using Service by Type of Service\*:  
Michigan Medicaid, 1981

	Ambulatory Care	Inpatient Hospital	Long-Term Care	Drugs	Dental
Categorically Needy/					
Receiving Cash	77.3%	13.0%	1.6%	68.7%	22.9%
Aged	70.7	23.5	9.9	80.5	5.5
Disabled	81.1	21.1	9.7	79.3	12.1
AFDC Child	74.1	7.1	0.3	60.5	29.0
AFDC Adult	82.0	20.5	0.6	79.7	16.6
Medically Needy	67.2	19.2	41.0	79.0	9.6
Aged	57.9	14.8	69.9	87.4	3.8
Disabled	82.7	29.3	23.6	82.7	9.7
AFDC Child	64.3	7.8	0.8	48.9	24.1
AFDC Adult	67.0	25.2	4.8	62.8	10.0
Total Medicaid	76.1	13.5	4.9	69.3	21.6
Aged	64.4	19.2	40.1	84.1	4.7
Disabled	81.6	23.1	12.8	80.2	11.5
AFDC Child	74.3	7.1	0.3	60.1	28.9
AFDC Adult	81.1	20.5	0.6	78.8	16.3

Source: Tables E-2-A-1 and E-3-G-4, S-4-H-1, S-6-H-4, Tape-to-Tape  
Early Returns Data, Michigan, 1981.

\*Calculated using person years of enrollment



Exhibit 3-23

Service Units Per Person-Year of Enrollment for Selected Services:  
Michigan Medicaid, 1981

	Ambulatory Visits	Inpatient Hospital Service Days	Prescribed Drugs	Long-Term Care-Days
Categorically Needy/				
Receiving Cash	5.2	1.3	8.9	2.7
Aged	4.9	4.1	26.5	20.0
Disabled	8.2	3.8	26.2	18.6
AFDC Child	4.1	0.6	3.5	0.4
AFDC Adult	6.6	1.7	11.8	0.1
Medically Needy	6.6	4.7	30.2	113.3
Aged	4.9	3.6	40.8	198.7
Disabled	10.7	8.4	31.5	56.4
AFDC Child	4.1	1.2	3.1	0.3
AFDC Adult	5.8	4.2	10.4	0.4
Total Medicaid	5.3	1.6	10.7	11.9
Aged	4.9	3.9	33.9	110.1
Disabled	8.8	4.9	27.7	27.1
AFDC Child	4.1	0.6	3.5	0.4
AFDC Adult	6.5	1.7	11.7	0.1

Source: Tables S-5-G-1 and S-5-H-1, Tape-to-Tape Early Returns Data,  
Michigan, 1981.

A majority of enrollees in each eligibility group used ambulatory care and drugs at least once during the year. The elderly and the disabled were the major recipients of long-term care (40% and 13% of enrollees, respectively). AFDC-related children were the major users of dental services (29% of enrollees). About one-fifth of aged, disabled and AFDC-related adults received inpatient hospital services, compared to only 7% for AFDC-related children.

Exhibit 3-23 shows even more dramatic differences among the eligibility groups. It depicts for Michigan the average units of service used per person year of enrollment for the major types of service. For ambulatory care, the data show that the disabled used by far the most services compared to other eligibility groups. They also averaged the greatest number of inpatient hospital days. The aged and the disabled received substantially more drug prescriptions per person year of enrollment than other groups. For long-term care, the aged, as one would expect, showed by far the greatest service use. For all services, the medically needy used more service units than cash recipients.

These utilization data help explain the per capita cost data presented earlier. Exhibit 3-24 depicts the service components of the per capita costs for Michigan for all the eligibility groups.

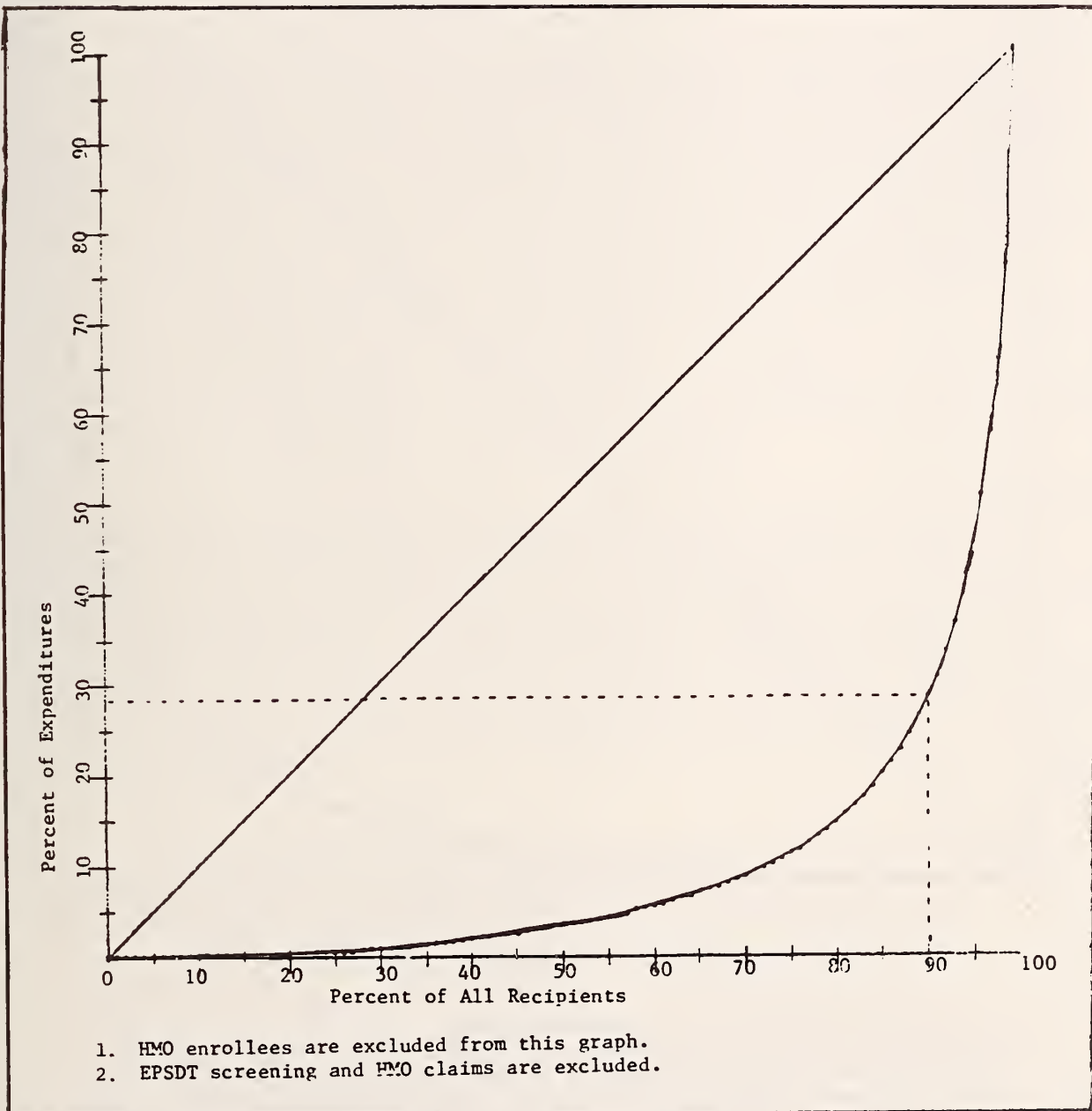
These utilization data for Michigan alone are not nationally representative. However, the eventual 5 State Tape-to-Tape data base will be very useful in understanding the enormous differences seen among eligibility groups in their experience with the Medicaid program.

#### 3.4.4 High Cost Users

A final capability of the Tape-to-Tape data base is that it can provide distributional data on Medicaid expenditures for each State. Although it has long been suspected that the use of "average" expenditure rates can be a very misleading analytic approach to understanding Medicaid costs, the Early Returns Data for Michigan and New York in 1981 on the distribution of expenditures among Medicaid recipients unquestionably confirm this suspicion. Exhibits 3-24 and 3-25 present a Lorenz curve for each State showing the cumulative distribution of expenditures across the recipient

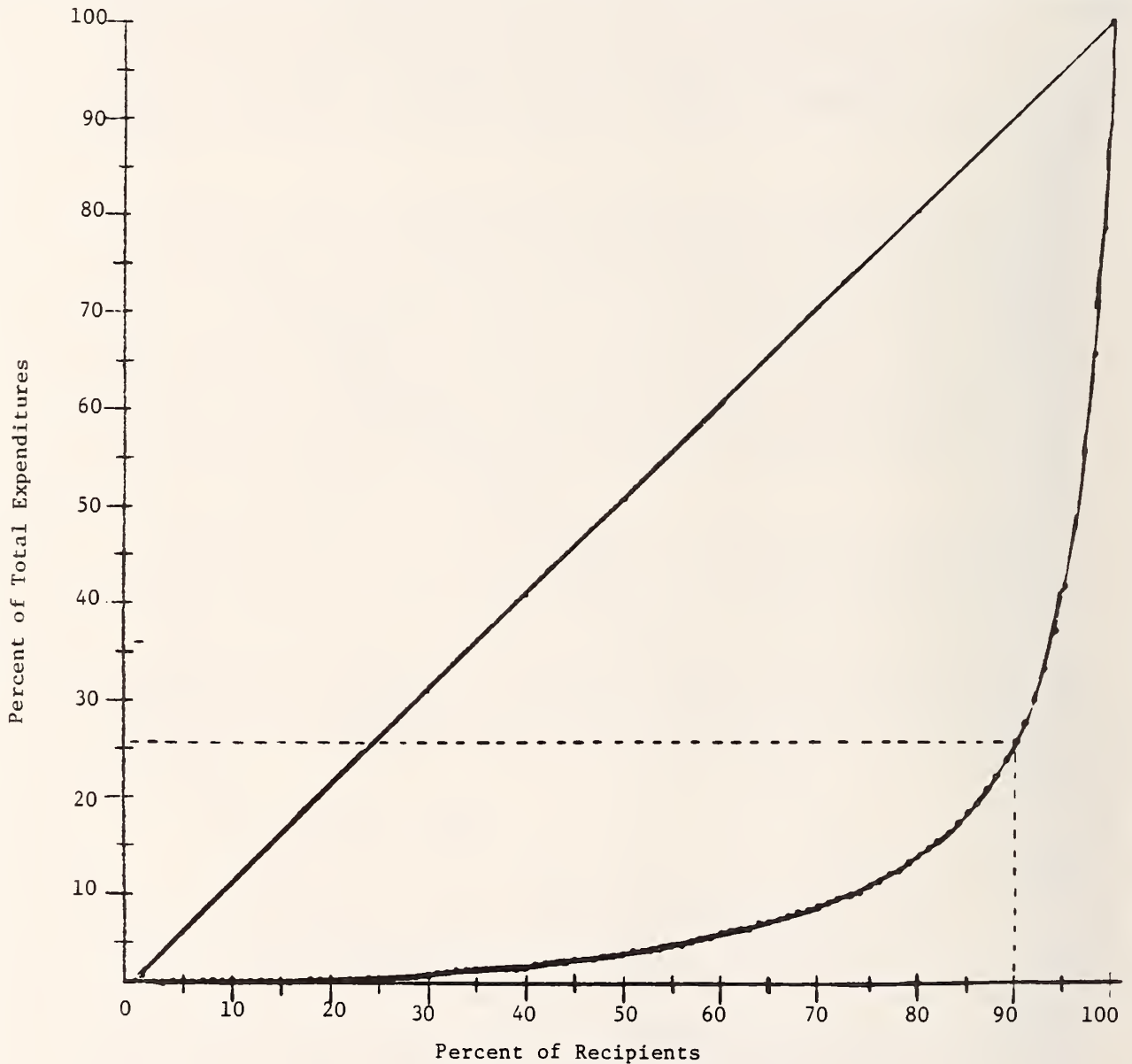
Exhibit 3-24

Distributional Analysis: Cumulative Percent of Total Expenditures and  
Percent of All Recipients: Michigan Medicaid, 1981



Source: Figure D-4-4 Tape-to-Tape Early Returns Data, Michigan, 1981.

Distributional Analysis: Cumulative Percent of Total Expenditures and  
Percent of All Recipients: New York Medicaid, 1981



1. HMO enrollees are excluded from this table.
2. EPSDT screening, HMO, capitated prepaid foster care, Office of Mental Health inpatient care, New York City personal and clinical psychologist care, and some upstate New York counties' services are excluded.

Source: Figure D-4-4, Tape-to-Tape Early Returns Data, New York, 1981.



population for 1981.<sup>28</sup> The curve which represents the actual distribution shows that expenditures were very unevenly distributed across the Medicaid recipient population in both States. As illustrated by the dashed line, 90% of recipients accounted for only 28% of expenditures in Michigan. In other word, expenditures for the top ten percent of recipients were 72% of total expenditures for the State. For New York, the top ten percent of recipients accounted for 75% of expenditures in 1981.

Exhibit 3-26 compares the eligibility group distribution of the high cost users to the overall Medicaid enrollee population in each State in 1981. Not surprisingly, in both States the medically needy are disproportionately represented among the high cost users. In Michigan, they were only 8% of all enrollees, but they accounted for 38% of the high cost users. In New York, the medically needy were 15% of enrollees, but 52% of the high cost group. Among the groups, in both States the high cost aged had the greatest disproportion of utilization. In Michigan, they were only 8% of enrollees, but were 31% of the high cost users. In New York, they were 15% of enrollees, but 51% of the high cost group. At the other extreme were AFDC-related children in both States. In Michigan, AFDC-related children were 53% of enrollees, but were only 11% of the high cost population. In New York, AFDC-related children were 9% of the high cost group, but 45% of enrollees.

Exhibit 3-27 compares the per capita expenditures of the high cost users to the per capita expenditures of the overall enrollee population for Michigan. It also breaks down expenditures by major service type. It shows the annual per capita expenditures in 1981 for a high cost user in Michigan were \$8864, compared to \$1171 for all enrollees. Thus, high cost users were about 7 1/2 times as expensive as the average enrollee. The major difference by type of service is that long term care accounted for half of the costs of the high cost group, whereas it was only 37% of costs for the overall population.

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<sup>28</sup>In the Lorenz Curve, recipients are ranked in ascending order by their Medicaid expenditures. Individual observations are combined to form a cumulative distribution, represented by the curved segment below the 45° line. The cumulative percent of total recipients is presented on the horizontal axis while the cumulative percent of total expenditures is displayed on the vertical axis. The 45° line shows the hypothetical distribution if the expenditure level for all recipients were equal. For example, were expenses evenly distributed among all recipients, then 90% of the recipients would account for exactly 90% of total expenditures. To the degree that the curve bends away from the 45° line, expenditures are more disproportionate.

Exhibit 3-26

Percent Distribution of High Cost Recipients and Total Enrollees by Eligibility Group and Cash Assistance: Michigan and New York, 1981

	Percent of Enrollees*			
	High Cost Recipients		All Enrollees	
	(Top 10% of Expenditures)			
	<u>MI</u>	<u>NY</u>	<u>MI</u>	<u>NY</u>
Categorically Needy/				
Receiving Cash	59.7	47.6	89.1	81.9
Aged	3.7	8.6	3.7	8.5
Disabled	14.9	20.6	7.6	12.6
AFDC Child	10.7	7.7	51.2	42.2
AFDC Adult	30.3	10.6	26.5	18.4
Medically Needy	38.3	51.7	8.2	15.1
Aged	27.0	42.1	4.0	6.5
Disabled	9.7	7.2	2.4	1.9
AFDC Child	0.2	0.9	0.7	3.1
AFDC Adult	0.6	1.0	0.6	1.9
Total Medicaid	100.0	100.0	100.0	100.0
Aged	31.1	50.6	8.0	15.0
Disabled	25.4	27.8	10.3	14.5
AFDC Child	11.0	8.7	53.0	45.3
AFDC Adult	31.6	11.6	28.0	20.3

\*Calculated using person years.

Source: Tables E-2-A-1 and E-2-B-12, Tape-to-Tape Early Returns Data, Michigan and New York, 1981.

Exhibit 3-27

Expenditures Per Person-Year and Percent of Total Expenditures for High Cost Recipients  
and Total Enrollees by Summary Service Type:  
Michigan Medicaid, 1981

	<u>Total</u>	<u>Type of Service</u>					
		<u>Inpatient hospital</u>		<u>Long Term Care</u>		<u>All other</u>	
	Expenditures per person- year	Percent	Expenditures per person- year	Percent	Expenditures per person- year	Percent	Expenditures per person- year
High-cost recipients	\$8864	100%	\$3066	34.6%	\$4466	50.4%	\$1332
							15.0%
Total enrollees	\$1171	100%	\$368	31.4%	\$432	36.9%	\$372
							31.8

Source: Tables X-5-H-1 and X-5-H-12, Tape-to-Tape Early returns Data, Michigan, 1981.

These distributional data are important to remember in any analysis of Medicaid costs. It will be interesting to see if the pattern seen in Michigan and New York hold true for the other Tape-to-Tape States.

### 3.5 Summary

The analyses presented throughout this chapter have substantiated that HCFA's emerging data system holds considerable potential for answering evaluation questions posed by policymakers regarding Medicaid eligibility concerns. The Program Characteristics data provide for the first time a comprehensive description of State eligibility policies. The 2082 data allow considerable analysis of aggregate patterns among States in Medicaid enrollment and expenditures, using the characteristics data to control for eligibility differences. Tape-to-Tape data permit a detailed person-based review of eligibility-related patterns in at least a few States. Similarly, MQC data have the potential for person-based analysis across a majority of the States.

This first attempt to utilize these data bases to study eligibility evaluation concerns has yielded results in several policy areas of interest, as summarized below:

- The Medically Needy. 2082 data indicate that a medically needy program increases the size of a State's recipient population by about 6%, assuming that most of the institutionalized are already enrolled in Medicaid as categorically needy, no-cash recipients. Overall, the per capita costs of medically needy recipients appear to be about 3 times as much as cash assistance recipients, or 1.8 if only the costs of the non-institutionalized medically needy are considered. This pattern of costs is not very different from that experienced by non-medically needy States with their categorically needy/no cash recipients. Notwithstanding these general patterns, enormous variation exists among States with regard to the medically needy program.
- Treatment of SSI Recipients. 2082 data and SSI statistics suggest that the State determination and 209(b) options reduce by about 30% the number of disabled categorically needy/cash Medicaid recipients for a State. However, the aged categorically needy/cash recipient population is not reduced by much with the State determination option. It is reduced by about 20% with the 209(b) option. Per capita expenditures for aged and disabled are greater in State determination and 209(b) States, calling into question how much money is saved by these options. The causes for the greater per capita expenditures are not known. However, these results must be interpreted with caution since a lot of variation is seen among States.



- MA-21 Children. Non-AFDC-related children in a State's Medicaid program cost a State about twice as much as AFDC/cash children. Covering all children in low-income families, as opposed to only certain classifications of them, appears to about double the size of the non-AFDC/cash child recipient group. As with other issues, a lot of variation exists among States in their experience with the MA-21 program.
- AFDC-U. This short-term evaluation yielded little analysis helpful to understanding the impact on Medicaid of covering AFDC-U recipients. AFDC program data show that coverage of AFDC-U usually expands the AFDC/cash population by about 6% (with considerable variation among States).
- Payment and Income Levels. Not surprisingly, 2082 data and census data suggest that States with higher payment and income levels for eligibility determination enroll proportionately more Medicaid recipients relative to the size of a State's poverty population than do States with lower levels.
- Overall Eligibility Policies of States. The study developed an eligibility classification scheme which grouped States according to the comprehensiveness of their overall Medicaid eligibility policies. The four key areas of eligibility policy which were used included: whether or not a State had a medically needy program; where it set its AFDC, SSI and medically needy income levels; whether or not it included the optional groups of AFDC-U and Ribicoff children; and whether or not it automatically extended Medicaid eligibility to SSI recipients. 2082 and census data showed that the most "liberal" States according to this scheme did enroll a greater proportion of the poor as Medicaid recipients. Interestingly, higher income levels appear to be a greater determinant of the size of the Medicaid population than the presence of a medically needy program with low income levels and limited or no key optional groups.
- Enrollee-Recipient Ratios. Tape-to-Tape data suggest that about 20% of Medicaid enrollees do not use any Medicaid services over a year's period. This rate varies somewhat by eligibility and cash assistance status, with some differences between States.
- Length of Enrollment. Tape-to-Tape data show that the medically needy have more turnover than cash assistance recipients. Among the eligibility groups, the disabled and the aged have less turnover than AFDC-related enrollees.

- Expenditure Patterns. Tape-to-Tape data allow for the calculation of annual costs by person-years of enrollment, i.e., the length of enrollment is taken into account in calculating annual per capita expenditures for the various eligibility groups. These data show an even wider disparity in costs between SSI-related and AFDC-related enrollees than shown with 2082 data. Greater differences are also shown by cash assistance status.
- High Cost Users. Tape-to-Tape data for New York and Michigan in 1981 show that 10% of recipients accounted for 72%-75% of total Medicaid expenditures. The medically needy are disproportionately highly represented among the high utilizers, as are the aged.

## Chapter 4

### INSTITUTIONALIZED RECIPIENTS

Medicaid policymakers know that strategies to contain Medicaid costs must include a strong focus on long-term care. Although clearly not an intent of the original legislation, Medicaid has become the primary public payor for nursing home care. Recipients of nursing home care comprised just 7.3% of the total Medicaid population in 1982, yet nursing home costs comprised 43% of all expenditures. Expenditures for nursing home care are also rising faster than expenditures for other Medicaid services, and consequently, constitute an increasing proportion of the total Medicaid budget. In 1973, payments to nursing homes accounted for 34% of total expenditures; in 1982, they accounted for 43%.

Medicaid expenditures for nursing homes are closely linked to overall trends in the nursing home industry, since Medicaid pays for just under half of all nursing home costs (Exhibit 4-1). Many of

#### Exhibit 4-1

#### Medicaid Expenditures for Nursing Home Care as a Percentage of Total Nursing Home Payments: 1973 - 1982

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<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>
42.9%	45.8%	48.1%	47.6%	49.0%	49.5%	49.3%	49.5%	47.9%	48.7%

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Sources: Fox, P.D. & Clauser, D.S. "Trends in Nursing Home Expenditures: Implications for Aging Policy." Health Care Financing Review 2(2): 65-70, Fall 1980 (for years 1973-1979) and Gibson, R.M. Waldo, D.R. and Levit, K.R. "National Health Expenditures, 1982." Health Care Financing Review 5(1): 1-31, Fall 1983 (for years 1980-1982).

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these costs are incurred by persons who enter nursing homes as private pay clients, but then convert to Medicaid after their

available assets are depleted. Private health insurance policies rarely include coverage of nursing home care, and Medicare benefits for nursing home care are limited.<sup>28</sup> Thus, almost by default, Medicaid has become the major "insurance" program for nursing home care, not only for elderly persons of low-income, but for middle-income persons who cannot afford the high cost of nursing homes for very long.

If Medicaid continues to pay for half of all nursing home costs over the coming decades, the effect on Medicaid expenditures will be enormous. By 1990, total payments for nursing homes are expected to rise to \$67 billion (Freeland and Schendler, 1983). The Medicaid nursing home bill would then be approximately \$33 billion, more than the entire Medicaid outlay for 1983. The longer term outlook is even more ominous, as the "baby boom" population cohort ages. Assuming current age-specific use rates remain stable, the total nursing home population will increase four times faster than the U.S. population as a whole over the next fifty years. Given these historical and projected trends in nursing home care, it is no surprise that some analysts predict that long-term care will be "the most problematic area of social policy over the next generation (Fox and Clauser, 1980).

The statistics cited above make it clear why Medicaid policymakers are interested in obtaining better information on the institutionalized Medicaid population. Development of alternative long-term care policies requires prerequisite knowledge of the current institutionalized population, and the proportion of that population which might be better served in alternative settings. Policymakers also express a need for descriptive data on the utilization and expenditure patterns of nursing home residents, and variations in these patterns across recipient characteristics and by State. In particular, they want to know how nursing home residents become eligible for Medicaid, what proportion of total care costs are paid by recipients through "spend-down" provisions, and what resources are potentially available from the families of institutionalized Medicaid recipients, should family cost-sharing requirements be enacted.

This chapter draws on various Medicaid data bases to describe the Medicaid nursing home population.<sup>29</sup> The chapter is

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<sup>28</sup>Nursing home coverage under Medicare's Hospital Insurance (HI) program is limited to 100 days of Skilled Nursing Facility Care per benefit period. In 1982, Medicare expenditures for nursing home care were \$500 million, equalling 1.8% of total nursing home care costs and about 1% of total Medicare outlays.

<sup>29</sup>The definition of the nursing home population adopted for this chapter includes recipients of ICF, SNF, and ICF-MR care. Recipients of inpatient psychiatric services and home health care services, who are often included in analyses of the Medicaid long-term care population, are excluded from this analysis.



divided into three major sections. The first section describes the 1982 Medicaid nursing home population and 1982 expenditures for nursing home care. The second section then summarizes trends in the Medicaid nursing home population and expenditures from 1975 to 1982. The final section examines Medicaid nursing home expenditures and trends at the State level, and attempts to explain the variations in Medicaid expenditures for nursing home care across States.

#### 4.1 1982 Medicaid Nursing Home Recipients and Expenditures

##### 4.1.1 Eligibility Status of Recipients

In 1982, approximately 1.5 million recipients of nursing home care had some portion of their nursing home bill paid for by Medicaid. Although precise data are not available, it is estimated that over half of all users of nursing homes receive some Medicaid benefits during the course of their nursing home stay (General Accounting Office, 1983). Almost all institutionalized recipients are SSI-categorically related: about 73% of all nursing home recipients are aged, while 26% are disabled (Exhibit 4-2). In contrast, the aged and disabled together make up less than one-fourth of the non-institutionalized Medicaid population. Within eligibility groups, 33% of all aged recipients and 14% of all disabled recipients received nursing home care at some point during 1982.

There are also major differences between the non-institutionalized and institutionalized Medicaid population by cash assistance status (Exhibit 4-3). Only about 17% of the non-institutionalized population is not receiving cash assistance from either SSI or AFDC. Among nursing home recipients, over 70% receive Medicaid without receiving cash assistance.<sup>30</sup> Thus, while nursing home recipients comprise only 7.3% of the total Medicaid recipient population, they comprise 27% of all non-cash recipients.

The large number of non-cash recipients among the institutionalized is due to the fact that all States make some provision for extending nursing home benefits to persons who are not receiving SSI/SSP. States do this in either one of three ways:

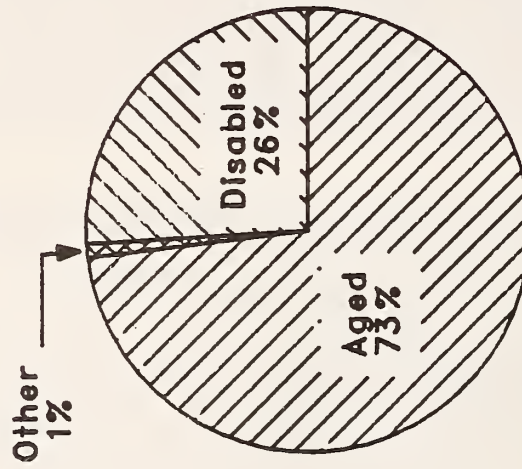
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<sup>30</sup>However, a large proportion of nursing home residents not receiving cash assistance would receive cash if they were not institutionalized.

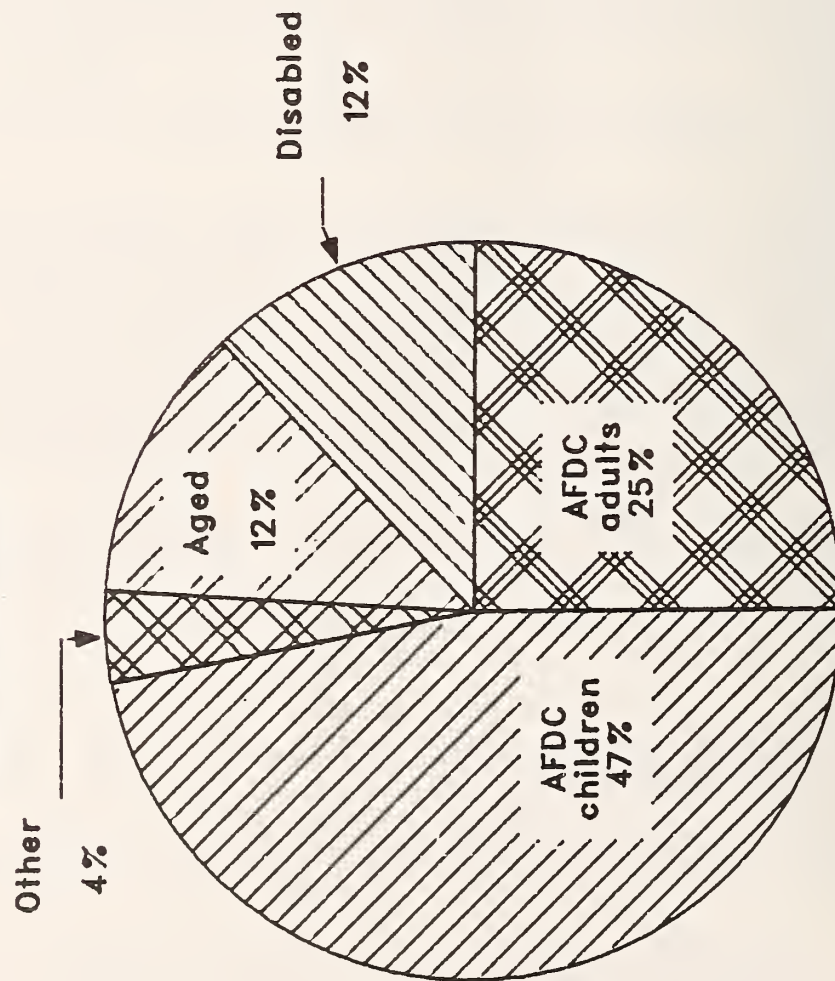
Exhibit 4-2

Distribution of Institutionalized and Non-Institutionalized Medicaid Recipients  
by Eligibility Group

**Institutionalized**  
1,478,000 recipients



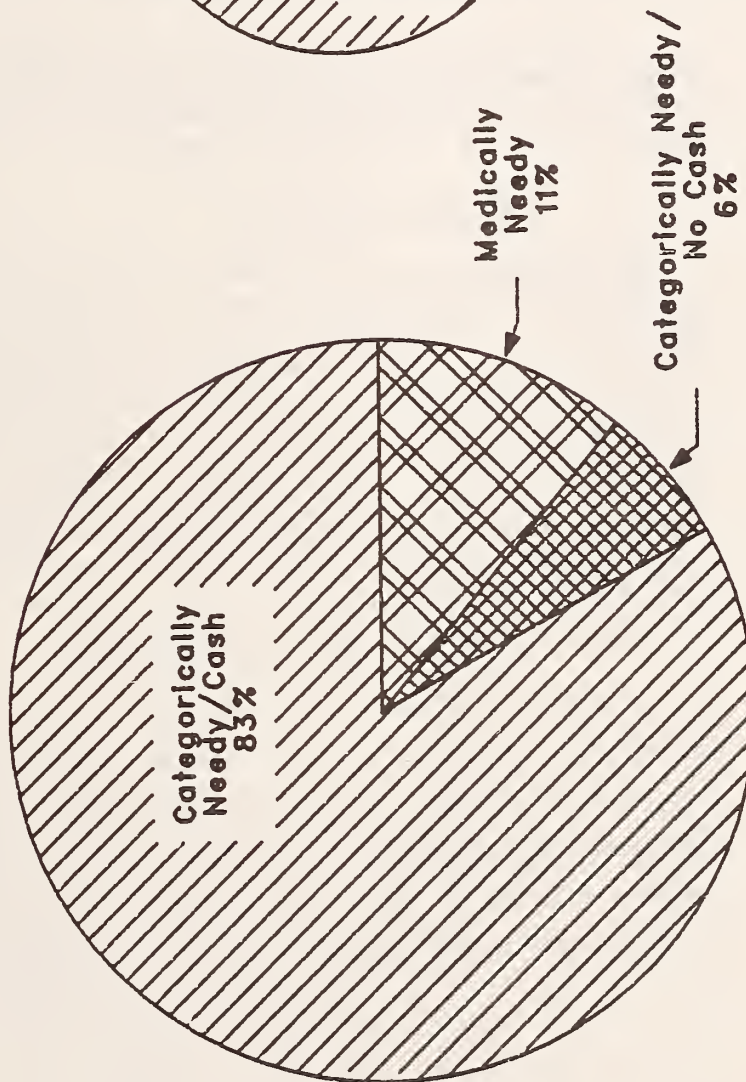
**Non-Institutionalized**  
20,458,000 recipients



Distribution of Institutionalized and Non-Institutionalized Medicaid Recipients  
by Cash Assistance Status

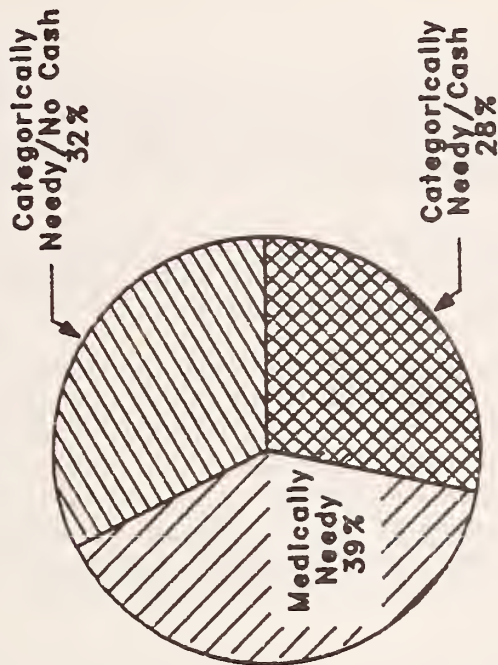
**Non-Institutionalized**

20,458,000 recipients



**Institutionalized**

1,478,000 recipients



Source: 1982 2082 data file



- Election of the medically need option, which allows nursing home recipients to "spend down" to medically needy income levels, after which Medicaid pays the balance between the reimbursement rate and patient contributions.
- Election of the 209(b) option, a condition of which is that 209(b) States must have a "spend-down" program for SSI-related recipients.
- Election of the "300% option," which extends coverage of nursing home benefits to persons with incomes up to 300% the basic Federal SSI benefit (\$265 per month for an individual living independently in 1982). This option provides Medicaid coverage in nursing homes to persons who would otherwise not be eligible for Medicaid if cared for outside a nursing home, and is frequently cited as an example of "institutional bias" in the Medicaid program.

Consequently, Medicaid eligibility options have relatively less effect on nursing home utilization by Medicaid recipients than other provisions of the Medicaid program such as limitations on benefits and nursing home reimbursement rates.

#### 4.1.2 Types of Care Used

Recipients of ICF care make up 51% of the Medicaid nursing home population, SNF recipients 38%, and ICF-MR recipients 10% (Exhibit 4-4). About 80% of all users of ICF and SNF care are aged, while 93% of all ICF-MR recipients are disabled, as would be expected. While disabled recipients make up the vast majority of ICF-MR recipients, it is important to note that almost two-thirds of the disabled nursing home population resides in ICFs or SNFs, not ICF-MRs. Thus, the disabled nursing home population is not just comprised of mentally retarded persons in ICF-MRs, but persons with a broad range of disabilities being cared for in a variety of nursing home settings.

#### 4.1.3 Characteristics of Recipients

The prototypical nursing home recipient is a widowed female 81 years old. Over seven out of ten nursing home recipients are female, and almost nine out of ten recipients do not have a non-institutionalized living spouse. While there are discrepancies between data sets, about one-fourth to one-third of all institutionalized recipients are over the age of 85. Medicaid



Number and Distribution of Medicaid Nursing Home Recipients by Eligibility Group  
and by Facility Type: 1982

Facility Type	<u>SNF</u>		<u>ICF</u>		<u>ICF-MR</u>		<u>TOTAL</u>	
	(n)	Facility Eligibility Distribution %	(n)	Facility Eligibility Distribution %	(n)	Facility Eligibility Distribution %	(n)	Facility Eligibility Distribution %
Aged	460,000	(80%) (42%)	627,000	(82%) (57%)	8,000	(5%) (1%)	1,095,000	(73%) (100%)
Blind & Disabled	106,000	(19%) (27%)	138,000	(18%) (36%)	142,000	(93%) (37%)	386,000	(26%) (100%)
Other	5,000	(1%) (45%)	3,000	(0%) (27%)	3,000	(2%) (27%)	11,000	(1%) (100%)
Total	571,000	(100%) (38%)	768,000	(100%) (51%)	153,000	(100%) (10%)	1,492,000	(100%) (100%)

Source: 1982 2082 data. Numbers are approximate.

Quality Control data show a higher proportion of non-elderly institutionalized recipients than either 2082 data or Tape-to-Tape data (Exhibit 4-5). Therefore, better data on the age distribution of institutionalized Medicaid recipients is still needed.<sup>31</sup>

Nursing home recipients on Medicaid are more likely to be long-stay residents than private pay nursing home residents (Exhibit 4-6). Analyses of the 1977 Nursing Home Survey (which included only SNF and ICF facilities) have shown that the total nursing home population can be divided into short-stayers and long-stayers. The majority of nursing home admissions are short-stayers (with an average length of stay of 1.8 months), but on any given day, long-stayers (with an average length of stay of 2.5 years) constitute over 90% of all nursing home residents. These long-stayers, who are more likely to be Medicaid recipients, thus consume the vast majority of resident bed days (General Accounting Office, 1983).

#### Exhibit 4-6

##### Length of Stay of Medicaid Nursing Home Recipients in Comparison to Private Pay Residents

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	<u>Medicaid Recipients</u>	<u>Private Pay Residents</u>
3 months	19%	32%
3-5 months	11%	12%
6-11 months	12%	13%
1 year to less than 3	29%	25%
3 years to less than 5	14%	10%
5 years or more	15%	8%
	<hr/> 100%	<hr/> 100%

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Source: 1977 Nursing Home Survey. Excludes ICF-MR facilities.

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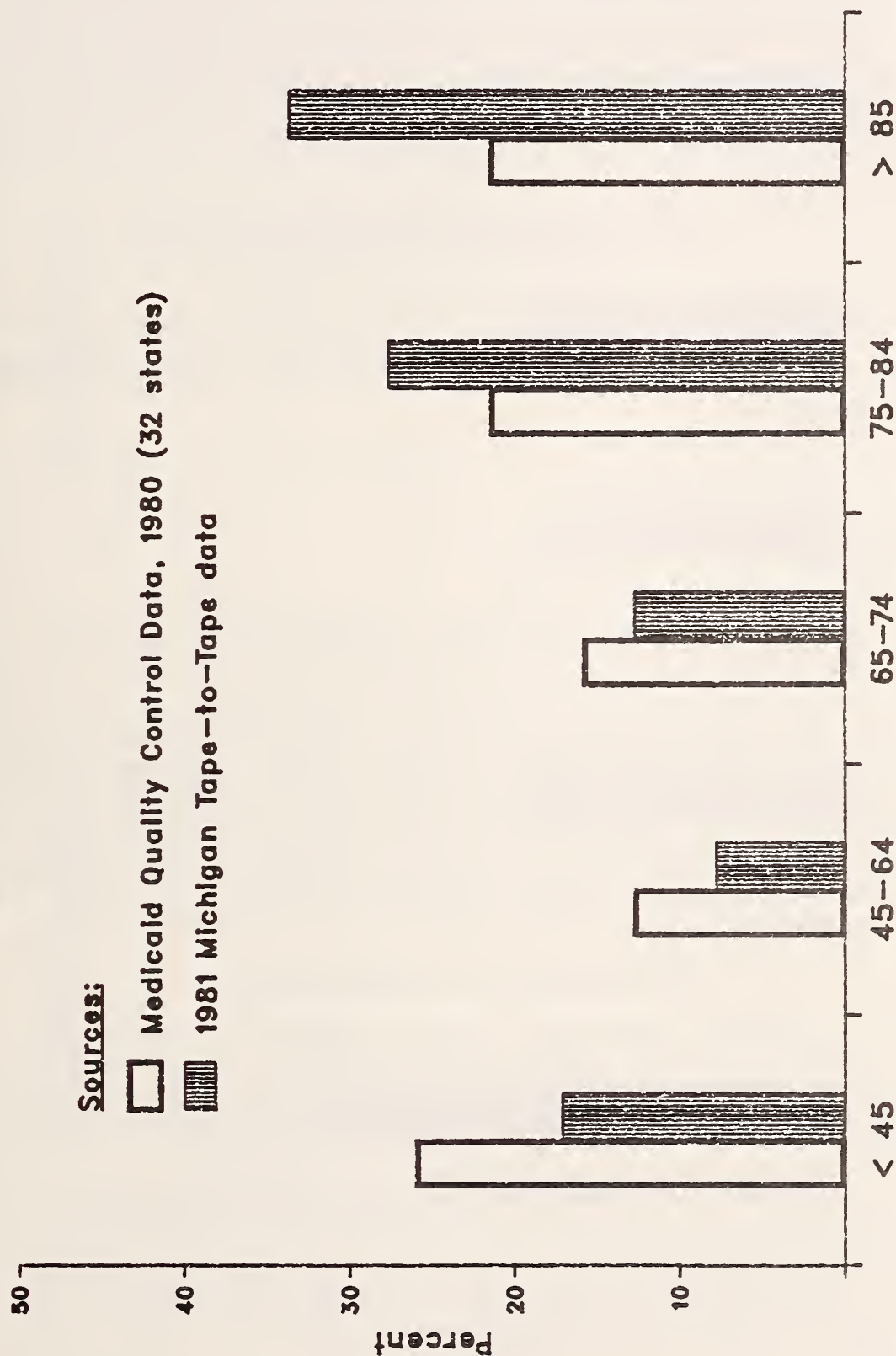
Private pay residents (who are also more likely to be short-stayers) are twice as likely as Medicaid recipients to be discharged back to a private or semi-private residence (Exhibit 4-7). Only about 15% of all institutionalized Medicaid

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<sup>31</sup>2082 data and Michigan Tape-to-Tape data indicate that the number of institutionalized recipients under age 65 to be about 25%, while MQC data show a non-elderly population of almost 40%. The 1977 Nursing Home Survey excluded ICF-MRs and therefore cannot be used as a data source for age distributions. 2082 data do not break out the over 65 age group into smaller age categories and were not used for Exhibit 4-5.

Exhibit 4-5

Age Distribution of Institutionalized Medicaid Recipients



recipients return to a non-institutionalized living arrangement. Thus, it is reasonable to assume that approximately 85% of Medicaid nursing home recipients will continue to be cared for in some type of institutional facility for the remainder of their lives. Since finding appropriate community-based care alternatives for recipients who are already institutionalized is exceedingly difficult, most initiatives to reduce nursing home utilization have consequently focused on diverting persons from nursing homes in the first place.

Exhibit 4-7

Discharge Status of 1976 Medicaid Recipients  
Versus Private Pay Residents

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	<u>Medicaid Recipients</u>	<u>Private Pay Residents</u>
Private or Semiprivate Residence	16%	31%
Another Health Facility	55%	41%
Deceased	29%	28%

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Source: 1977 Nursing Home Survey. Excludes ICF-MR facilities.

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The recent GAO study also provides some data on persons who convert from private pay to Medicaid. Using longitudinal data from the State of Minnesota for the years 1976-1980, GAO conservatively estimated that about 27% of all Medicaid recipients first entered nursing homes as private pay clients (General Accounting Office, 1983). Given the importance of this issue, GAO recommended that the 1985 Nursing Home Survey be designed to be able to track transitions in facility use and payment sources for an admission cohort of nursing home patients over a period of 12 to 24 months.

4.1.4 1982 Expenditures for Nursing Home Care

Although nursing home recipients comprise but 7.3% of all Medicaid recipients, nursing home costs account for over 43% of all Medicaid expenditures.<sup>32</sup> In 1982, Medicaid expenditures for nursing home care were just under \$13 billion, while total Medicaid expenditures were almost \$30 billion.

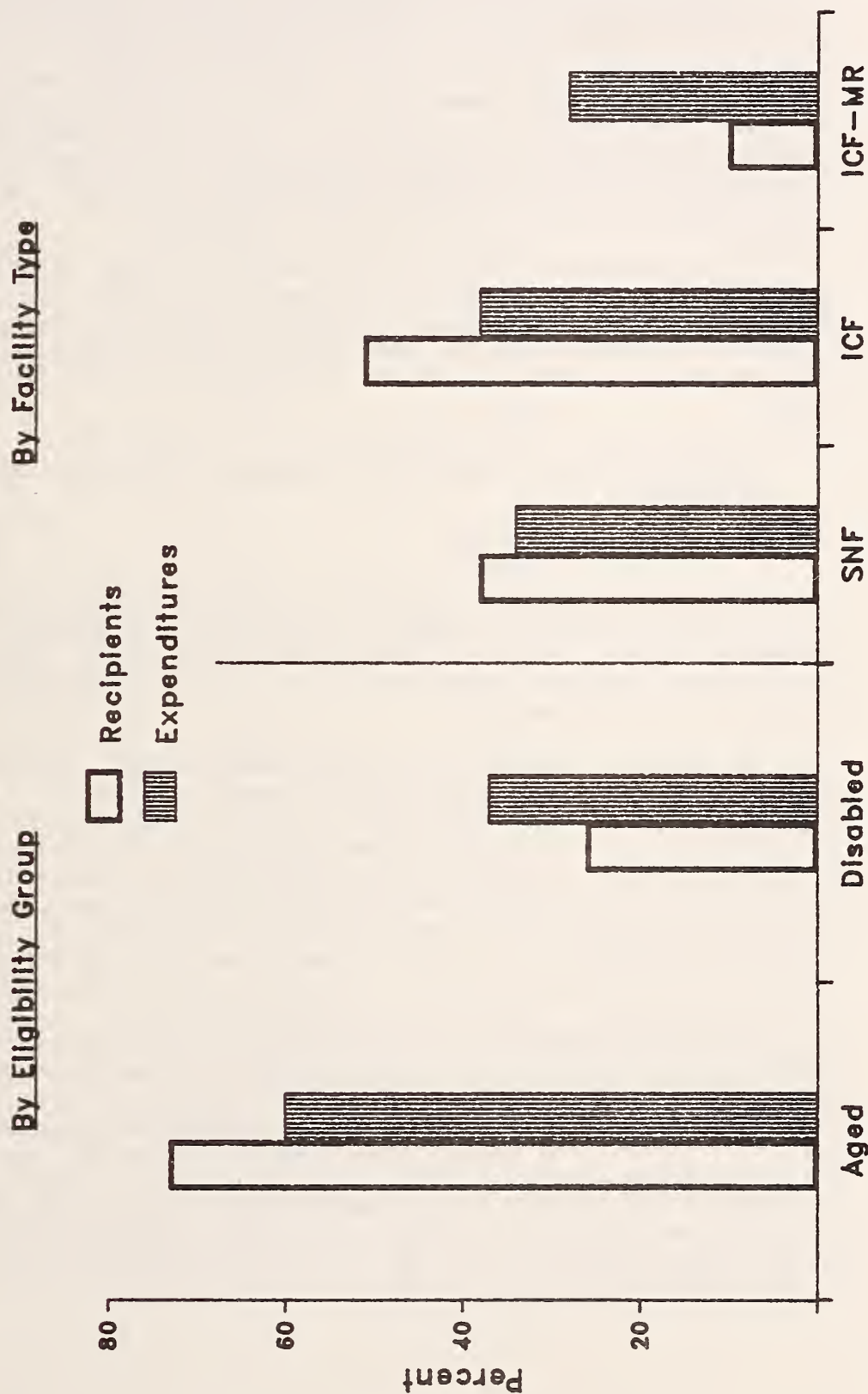
Exhibit 4-8 presents the distribution of nursing home expenditures by eligibility group and by type of facility, in

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<sup>32</sup>Nursing home recipients also incur costs over and above the cost of nursing home care (see Section 4.3).



Distribution of Nursing Home Recipients and Expenditures by Eligibility Group and Facility Type



Source: 1982 2082 data file

comparison to the distribution of recipients. The disabled are a more costly population to serve overall than the aged, incurring about 38% of all nursing home expenditures while comprising 26% of the nursing home population. This difference is largely due to the high cost of ICF-MR care for mentally retarded recipients. As shown in Exhibit 4-9, the average costs for aged and disabled recipients of ICF and SNF care are comparable, while the average cost of serving ICF-MR recipients, at \$23,435, is over three times the cost of serving ICF or SNF recipients. Thus, while ICF-MR recipients comprised only 10% of the all institutionalized recipients in 1982, they accounted for 28% of nursing home expenditures.

It is necessary to note that the average cost per recipient is a combined measure of (a) utilization and (b) price per day of nursing home care. Differences in average costs per recipient, as presented in Exhibit 4-9, can therefore be due to differences in average lengths of stay as well as to differences in the price of care.

#### 4.2 Recent Trends in Nursing Home Utilization and Expenditures: 1975-1982

##### 4.2.1 Recipient Trends

While the total number of Medicaid recipients declined slightly between 1975 and 1982, the number of nursing home recipients increased by about 166,000 recipients, or 1.7% per year. Thus, nursing home recipients grew from 6.4% to 7.3% of all Medicaid recipients over this period.

The growth in the Medicaid nursing home population has not been steady. There was substantial growth between 1975 and 1977, followed by two years of essentially no growth from 1977-1979, again followed by two years of significant growth from 1979-1981. Of particular interest, however, is that for the most recently reported year (FY 1982), the Medicaid nursing home population declined by about 125,000 recipients, or 8%. Predictions about whether this population decline is the start of a new trend in the Medicaid program would be mere speculation at the time of this writing.

An alternate method for measuring growth in the Medicaid nursing home population is to compute trends in rates of institutionalization. Exhibit 4-10 below presents the number of aged Medicaid nursing home recipients per 10,000 elderly population for 1975 to 1982. The exhibit shows that the rate of institutionalization fluctuated over the period, reaching its peak in 1976, and its lowest point in 1982. Thus, aged Medicaid nursing home recipients as a proportion of the total elderly population seems to be declining moderately. The rate of institutionalization was 6% lower in 1982 than it was in 1975.

Exhibit 4-9

Medicaid Costs per Nursing Home Recipient by Type of Facility,  
Eligibility Group, and Maintenance Assistance Status: 1982

<u>Average Cost Per Recipient Per Year</u>			
<u>Eligibility Group</u>	<u>SNF</u>	<u>ICF</u>	<u>ICF-MR</u>
CN/Cash, Total	\$6,113	\$6,874	\$22,455
Aged	5,673	6,576	--
Disabled	6,966	7,341	23,046
CN/No Cash, Total	6,542	6,086	18,912
Aged	6,389	5,988	--
Disabled	7,248	6,529	19,197
Medically Needy, Total	9,026*	6,288	26,950
Aged	9,629*	6,504	--
Disabled	6,057	4,973	27,738
Total	\$7,855	\$6,499	\$23,435

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\* Average costs per recipient of SNF care for the aged medically needy is highly skewed by the state of New York which accounted for 40% of all SNF expenditures for the medically needy, and where the average cost per aged medically needy SNF recipient was \$19,400. The average cost per aged medically needy SNF recipient, excluding New York, was \$6,406.

Source: 1982 2082 data.

Exhibit 4-10

Number of Aged Medicaid Nursing Home Recipients  
Per Elderly: 1975 - 1982

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<u>Year</u>	<u>Aged Recipients/10,000 Elderly</u>	<u>Aged Recipients/10,000 Elderly Below Poverty Level</u>
1975	443	2900
1976	461	3070
1977	456	3320
1978	439	3150
1979	425	2900
1980	438	2870
1981	435	2970
1982	415	2970

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Sources: 2082 data file and U.S. Bureau of the Census, Preliminary Estimates of the Population of the United States, by Age, Sex and Race: 1970 to 1981.

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The exhibit also shows the rate of institutionalization within the elderly poverty population. By this measure, the rate of institutionalization has also declined since 1977, but remained somewhat higher in 1982 than in 1975.

The number of Medicaid nursing home recipients is growing faster than the total number of aged and disabled persons receiving Medicaid, however. The entire aged Medicaid population declined by 7.5% between 1975 and 1982, while the aged nursing home population increased 10.9%. The disabled population as a whole increased 25%, but the disabled nursing home population increased at an even faster rate, 33%. Thus, the proportion of all aged recipients receiving institutional care rose from 28 to 33 percent over this interval, and the proportion of disabled recipients receiving institutional care rose from 13 to 14 percent.

To complete the utilization picture, it would be interesting to know recent trends in the proportion of all aged nursing home recipients receiving Medicaid. In other words, of all persons being care for in nursing homes, is the proportion of persons receiving financial assistance from Medicaid increasing, declining, or remaining stable? Unfortunately, these data are not available. Of particular interest would be whether the Medicaid nursing home



population as a proportion of all nursing home residents is declining, or whether total nursing home utilization rates among the aged are declining as well. If total utilization rates have been stable, the data cited above suggest that the proportion of all nursing home recipients on Medicaid is declining moderately, but not as quickly as the decline in the overall poverty rate among elderly persons. Reductions in the poverty rate among the elderly may have only marginal effects on the size of the aged Medicaid nursing home population, since nursing home admission is probably in and of itself a major cause of poverty among the nation's elderly. Thus, while continuing improvements in the economic status of elderly persons may lead to further reductions in the participation of elderly persons in the Medicaid program as a whole, such economic improvements will probably have less effect on the growth of the aged Medicaid nursing home population, given the high cost of long-term nursing home care.

There was significant change in the distribution of nursing home recipients by type of nursing home provider between 1975 and 1982 (Exhibit 4-11). The number of SNF recipients has been steadily declining while the number of ICF recipients has been rising. It appears that ICF care is now being substituted in many cases for Medicaid nursing home recipients who formerly would have received SNF care. Further, there has been almost a three-fold rise in the number of ICF-MR recipients, from about 54,000 to 154,000 recipients between 1975 and 1982. The proportion of all nursing home recipients who were cared for in ICF-MRs rose from 4 to 10 percent over this period.

The 1981-1982 decline in the Medicaid nursing home population affected SNF and ICF-MR recipients, but not ICF recipients. The SNF population declined by about 12%, and 77,000 persons, while the ICF-MR population declined by over 20%, and 42,000 persons.<sup>33</sup>

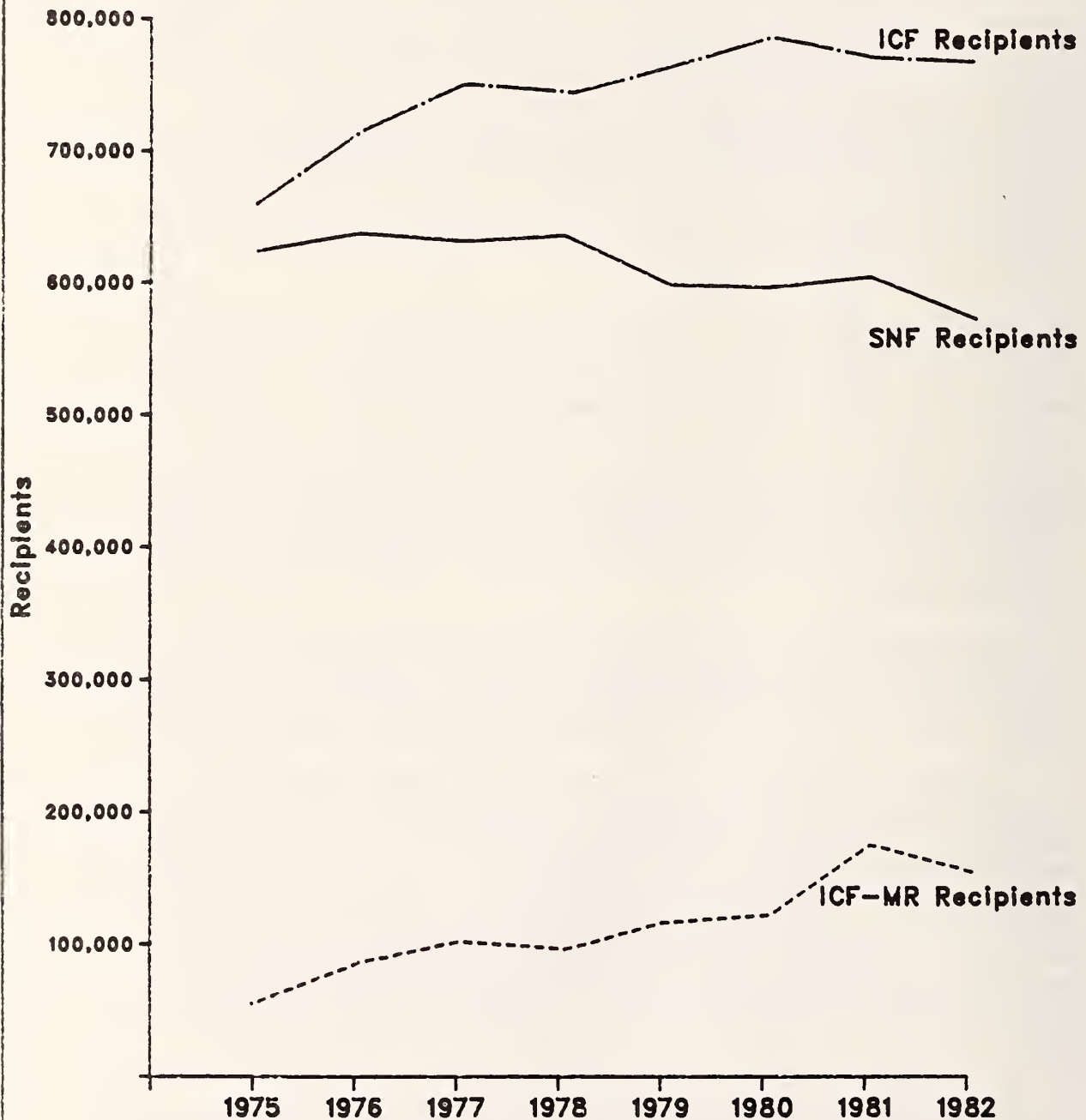
Exhibit 4-12 summarizes changes in the Medicaid nursing home recipient population in comparison to changes in the total Medicaid population, by type of nursing home care. The growth of the Medicaid nursing home population appears to bear little relationship to changes in the size of the total Medicaid population. If anything, there is an inverse relationship. Again, the dramatic decline in the number of institutionalized recipients between 1981 and 1982 is a trend reversal worthy of closer inspection. Of a total decline of 137,000 Medicaid recipients during 1982, 125,000 are accounted for by the decline within the institutionalized

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<sup>33</sup>Changes in ICF-MR recipients and expenditures can be affected by ICF-MR certification and decertification processes, as well as by changes in utilization.

Exhibit 4-11

Institutionalized Recipients by Facility Type: 1975-1982



Source: 2082 data file

Exhibit 4-12

Annual Compound Rates of Growth (ACRG) for Skilled Nursing Facilities (SNF), Intermediate Care Facilities (ICF), And Intermediate Care Facilities for the Mentally Retarded (ICF-MR), Recipients for 1975 - 1982: 2082 Data

	<u>Recipients</u>				
	<u>SNF</u>	<u>ICF</u>	<u>ICF-MR</u>	<u>All Nursing Home Recipients</u>	<u>All Medicaid</u>
ACRG 1975-1982	-1.3%	2.4%	16.2%	1.7%	-0.1
ACRG 1975-1980	-0.1	4.1	18.3	3.0	-0.4
ACRG 1980-1982	-4.3	-1.5	11.0	-1.5	0.8
Percent Change 1981-1982	-12.1	-0.8	-21.4	-7.8	-0.6
1982 Recipients	558,000	766,000	154,000	1,478,000	21,936,000

population alone. Of particular interest is whether this decline in the institutionalized Medicaid population is a result of consciously-applied policies of State Medicaid agencies, such as moratoriums on nursing home bed construction, the expansion of community-based service alternatives, etc., or whether it is a result of more indirect factors, such as the improved economic status of the elderly persons, increasing refusals of nursing homes to accept public assistance clients, or court orders for the deinstitutionalization of retarded persons.

#### 4.2.2 Expenditure Trends

Expenditures for nursing home care rose from \$4.7 billion in 1975 to just under \$13 billion in 1982. Expenditures for disabled nursing home recipients have been rising somewhat more rapidly than for the aged. In 1975, the disabled comprised 22% of all Medicaid nursing home recipients, and accounted for 24% of nursing home expenditures. In 1982, they made up 26% of the population, a slight increase, but their proportion of expenditures had increased to 38% of the total.

Expenditures for ICF-MR care have risen much more rapidly than ICF and SNF expenditures (Exhibit 4-13). In 1982, the distribution of Medicaid expenditures by type of nursing home care was markedly different from 1975 (Exhibit 4-14).

Exhibit 4-14

#### Distribution of Medicaid Nursing Home Expenditures by Type of Care: 1975 and 1982

	<u>1975</u>	<u>1982</u>
SNF	.52	.34
ICF	.40	.38
ICF-MR	.08	.28
	<u>1.00</u>	<u>1.00</u>

Total nursing home expenditures grew at an Annual Compound Rate of Growth (ACRG) of 15.7% between 1975 and 1982, compared to 13.5% for all of Medicaid (Exhibit 4-15). Although the nursing home population declined substantially between 1981 and 1982, as indicated previously, expenditures for nursing home care still increased more rapidly than expenditures for other Medicaid services.



Exhibit 4-13

Nursing Home Expenditures by Facility Type: 1975-1982

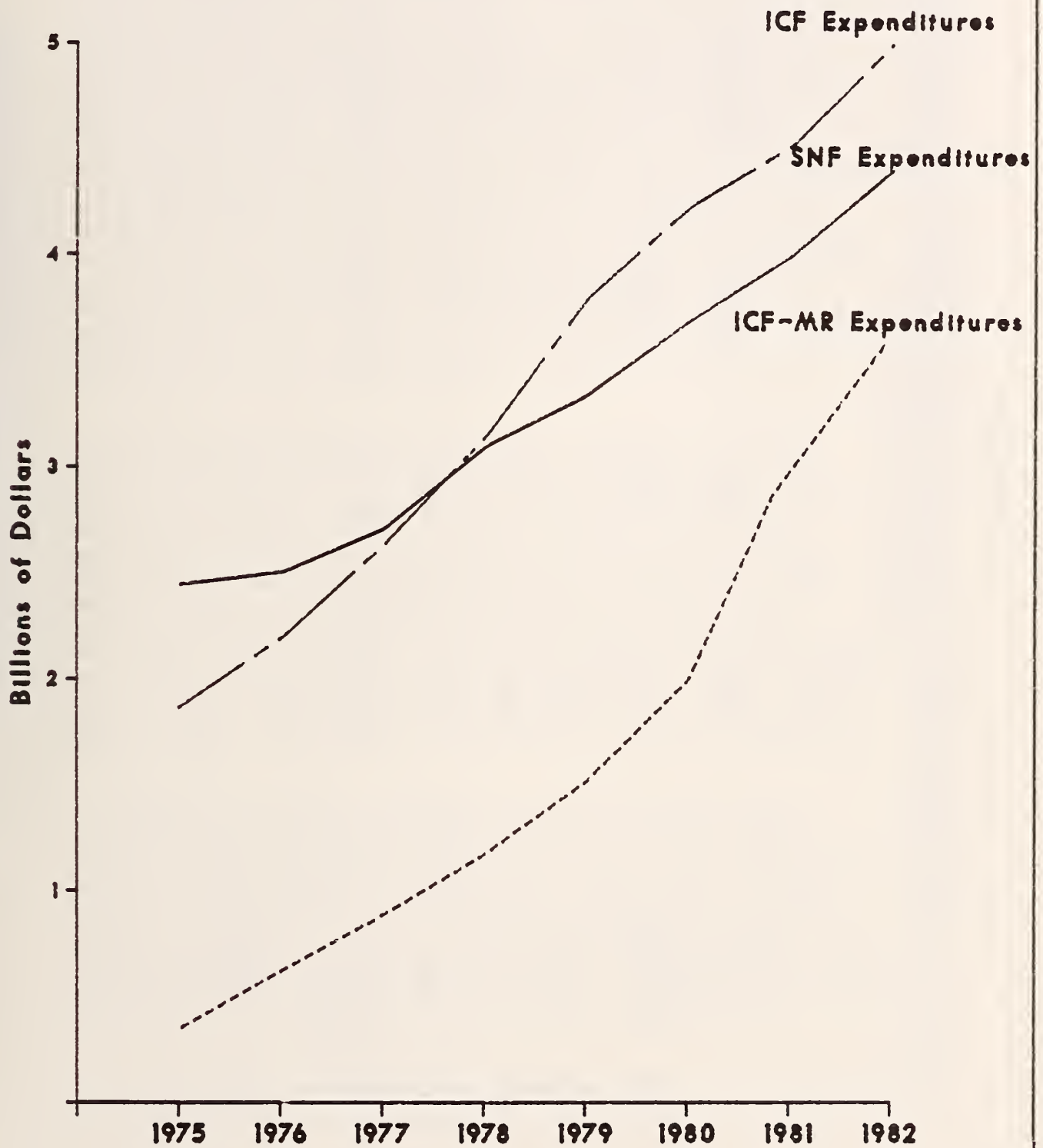


Exhibit 4-15

Annual Compound Rates of Growth (ACRG) for Skilled Nursing Facilities (SNF),  
Intermediate Care Facilities (ICF), and Intermediate Care Facilities for the Mentally Retarded (ICF-MR),  
Expenditures for 1975 - 1982

		<u>SNF</u>	<u>ICF</u>	<u>ICF-MR</u>	<u>All Nursing Home Care</u>	<u>All Medicaid Services</u>
ACRG	1975-1982	8.7	15.0%	39.6%	15.7%	13.5%
ACRG	1975-1980	8.7	17.7	41.5	16.3	13.7
ACRG	1980-1982	8.7	8.7	35.1	14.4	13.3
Percent Change	1981-1982	5.4	10.9	23.3	12.0%	9.6
1982 Expenditures (in \$000s)		\$4,382,746	\$4,977,902	\$3,608,693	\$12,969,341	\$29,905,882

Source: 2082 data file

One can control for the effects of recipient population changes on expenditure growth by looking at average costs per nursing home recipient (Exhibit 4-16). Increases in the average cost of ICF-MR care per recipient have been the most dramatic, rising from \$6,463 in 1975 to \$23,435 in 1982. Exhibit 4-17 summarizes ACRGs for average costs per nursing home recipient by facility type from 1975-1982. This exhibit makes several interesting points. First, increases in average costs per nursing home recipient have been approximately equal to increases in the average cost for all Medicaid recipients. This means that over the entire period nursing home expenditures have increased as a proportion of total Medicaid expenditures entirely due to increases in the number of institutionalized recipients relative to non-institutionalized recipients, not to greater increases in price and/or utilization. However, more recently, this has not been the case. Between 1980 and 1982, average costs for nursing home recipients have been increasing more rapidly than for non-institutionalized recipients. Between 1980 and 1982, the average cost per nursing home recipient increased by 16.1% annually compared to only a 11.4% for non-institutionalized recipients.

Thus, recent declines in the number of institutionalized Medicaid recipients may to some degree be offset by rising per capita costs for those persons who are institutionalized and on Medicaid. These data appear to support findings reported in the recent GAO study that Medicaid may be serving a nursing home population with increasing dependency levels. Using longitudinal data from the State of Minnesota for the years 1976-1979, GAO's analysis found that for almost every category of functional activity, Medicaid recipients were becoming increasingly dependent over time. This trend held true for new Medicaid admissions as well as for the total Medicaid nursing home population. GAO concludes that increasing dependency levels "could result in higher costs to nursing homes and Medicaid for each patient" (General Accounting Office, 1983).

While GAO's analysis included only elderly nursing home recipients, 2082 data indicate that ICF-MR per capita costs are another large factor behind overall increases in the average cost of serving Medicaid nursing home recipients. Increases in average costs for ICF recipients have generally lagged behind total per capita cost increases. On the other hand, average per capita costs for SNF recipients, which increased slowly between 1975-1980, accelerated rapidly in the 1980-1982 period. In light of both GAO's findings and the trends in per capita costs for nursing home

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Exhibit 4-16

Average Cost Per Medicaid Nursing Home Recipient by Facility  
Type: 1975-1982

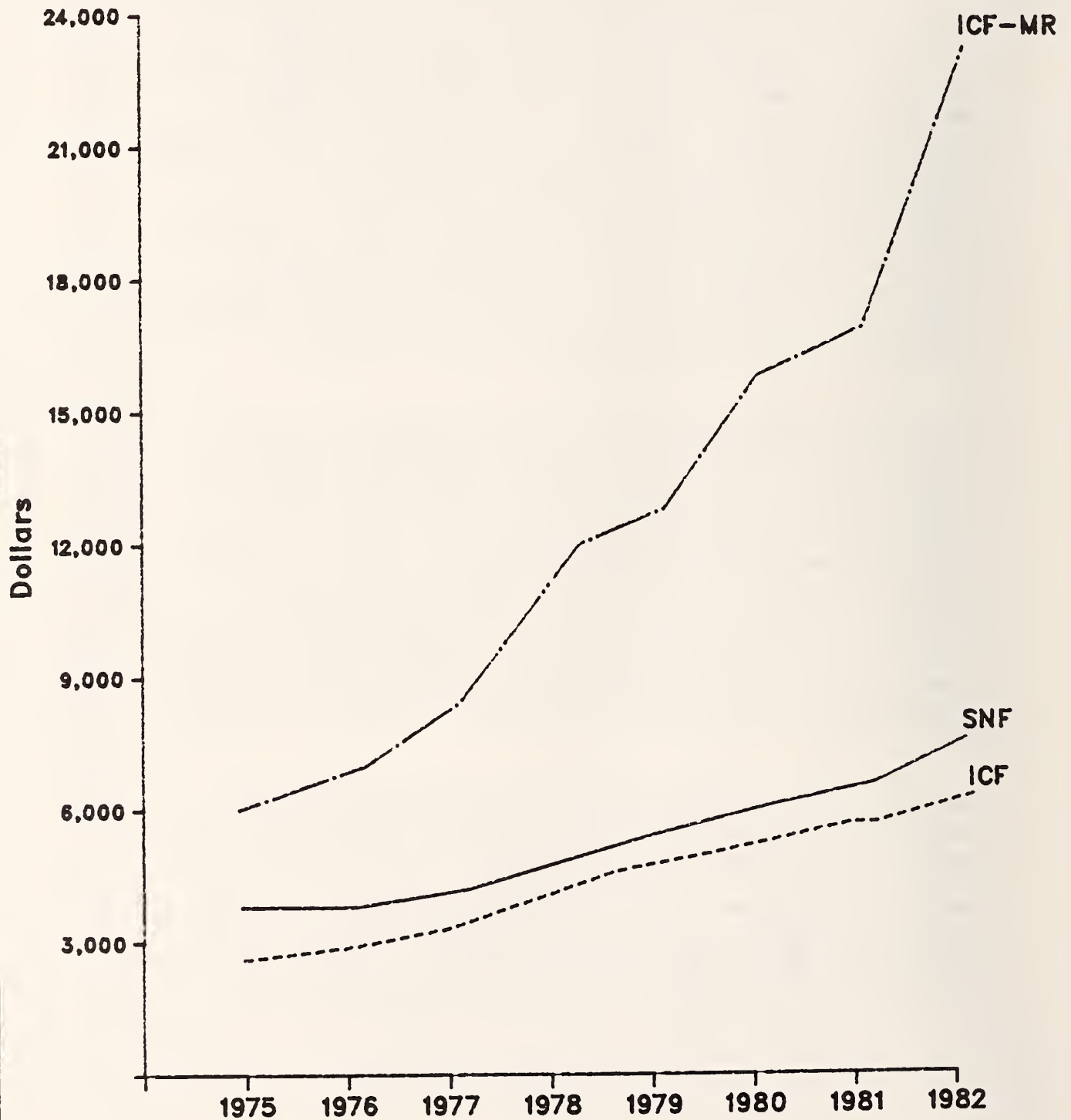




Exhibit 4-17

Average Annual Compound Rates of Growth (ACRG) for Skilled Nursing Facilities (SNF), Intermediate Care Facilities (ICF), and Intermediate Care Facilities for the Mentally Retarded (ICF-MR), Costs Per Recipient for 1975-1982: 2082 Data

		SNF	ICF	ICF-MR	All Nursing Home Care	All Medicaid Services	Medical Component of CPI
ACRG	1975-1982	10.1%	12.3%	20.2%	13.8%	13.6%	10.0%
ACRG	1975-1980	8.8	13.1	19.6	12.9	14.1	9.5
ACRG	1980-1982	13.6	10.2	21.7	16.1	12.4	11.2
Percent Change	1981-1982	19.9	11.7	56.9*	21.5	10.3	11.6
1982 Average Costs per Recipient		\$7,855	\$6,499	\$23,435	\$8,775	\$1,363	--

\* This dramatic increase is partly, perhaps largely, attributable to the fact that 2082 expenditure data are for date of payment, not date of service. Thus 1982 expenditures for ICF-MR care to some degree reflect payments for services rendered in 1981, when there was a large increase (57%) in the number of reported ICF-MR recipients. In general, therefore, average cost per capita data, as presented in this exhibit, are more accurate over longer time intervals than over shorter time intervals (e.g., 1981-1982 percent change).

recipients cited above, it appears that the Medicaid nursing home case mix is changing rapidly, with resulting effects on utilization and costs. Further examination of this changing case mix appears warranted.

Closer examination of the factors underlying the dramatic rise in per capita costs for ICF-MR care also appears warranted, given that the average cost of serving ICF-MR recipients has been increasing at the remarkable rate of 20.2% annually. One explanation may be the high cost of converting State institutions for the retarded to ICF-MR certification. Those facilities which could be converted to ICF-MR standards at lower cost may have come into the Medicaid program earlier on, at lower reimbursement rates, whereas the older and larger facilities, which have required major capital investments to meet ICF-MR standards, may have come into the program only more recently, at much higher reimbursement rates. These older, larger facilities are also more likely to be serving retarded persons with more severe disabilities, with consequent higher direct care costs. In any case, it is clear that the extremely high cost of ICF-MR care will be a growing focus of Medicaid cost containment policies at both the Federal and State levels.

#### 4.3 Variations in Nursing Home Utilization and Expenditures by State

Nursing home expenditure patterns, utilization rates, and costs per recipient vary considerably by State. Exhibit 4-18 presents Annual Compound Rates of Growth in nursing home expenditures for all States from 1975 to 1982. The highest rates have occurred in the smaller States with low absolute expenditures, while the larger States with higher absolute expenditures have experienced the lowest rates of growth in recent years.

The proportion of total Medicaid expenditures spent on nursing home care ranged from one-fifth of total expenditures in California to about two-thirds of all expenditures in New Hampshire (Exhibit 4-19).

California also had the lowest average cost per recipient (\$5,222) and Alaska the highest (\$16,300) (Exhibit 4-20). Across all States, the average cost per recipient of institutional care was \$8,775. This compares to an average cost of \$1,458 for all recipients, and about \$881 for non-institutional recipients

One clear variation across States is in the utilization of SNF care. In New York, for example, the majority of all recipients and expenditures are for SNF care. Other States, however, use SNF care infrequently. States with low average costs for SNF care may have aggressive policies for discharging SNF recipients prior to their conversion from Medicare to Medicaid, and/or may have more difficulty getting Medicaid recipients into SNFs due to low vacancy rates and preference given to private pay residents by SNF providers.

Exhibit 4-18

Annual Compound Rates of Growth (ACRG) in Nursing Home Expenditures:  
1975 - 1982

1. Missouri	32.1	26. North Dakota	16.6
2. West Virginia	32.3	27. Utah	16.5
3. Alaska	26.5	28. New Jersey	16.4
4. Delaware	26.5	29. Florida	16.3
5. Nevada	23.8	UNITED STATES	15.7
6. South Carolina	23.0	30. Vermont	15.4
7. Kentucky	22.6	31. District of Columbia	14.3
8. North Carolina	22.4	32. Kansas	13.7
9. Louisiana	21.0	33. Arkansas	13.5
10. New Hampshire	20.9	34. Idaho	13.5
11. Hawaii	20.6	35. Indiana	13.5
12. Ohio	20.4	36. Illinois	13.5
13. New Mexico	20.2	37. Connecticut	13.0
14. Maryland	20.1	38. Oregon	13.0
15. Virginia	19.8	39. Colorado	12.6
16. Rhode Island	19.4	40. Alabama	12.2
17. Maine	18.3	41. Texas	11.9
18. Mississippi	18.2	42. Georgia	11.8
19. Tennessee	18.1	43. Nebraska	11.7
20. Wyoming	18.0	44. New York	11.4
21. Iowa	17.4	45. Michigan	11.0
22. Washington	17.3	46. Pennsylvania	11.0
23. South Dakota	17.1	47. Oklahoma	10.8
24. Montana	17.1	48. Wisconsin	10.8
25. Minnesota	16.8	49. Massachusetts	10.3
		50. California	9.6

Exhibit 4-19

Proportion of Total Medicaid Expenditures Spent on Institutional  
Long-Term Care: 1982 2082 Data

1. New Hampshire	.67	26. Kansas	.50
2. Minnesota	.66	27. Missouri	.50
3. Alaska	.66	28. Oklahoma	.49
4. Idaho	.61	29. Rhode Island	.48
5. South Dakota	.60	30. Hawaii	.47
6. Connecticut	.60	31. Kentucky	.46
7. Wisconsin	.60	32. Maryland	.46
8. North Dakota	.58	33. Indiana	.45
9. Wyoming	.57	34. Tennessee	.45
10. Arkansas	.57	35. Delaware	.45
11. Oregon	.56	36. Alabama	.45
12. Nebraska	.55	37. Mississippi	.45
13. Texas	.55	38. New Jersey	.44
14. Louisiana	.54	UNITED STATES	.43
15. Iowa	.54	39. Nevada	.43
16. Washington	.54	40. Georgia	.43
17. Pennsylvania	.54	41. Massachusetts	.42
18. Utah	.53	42. New York	.42
19. South Carolina	.52	43. Florida	.41
20. Maine	.52	44. Ohio	.41
21. Colorado	.52	45. Illinois	.38
22. Vermont	.51	46. Michigan	.37
23. North Carolina	.51	47. New Mexico	.36
24. Virginia	.51	48. West Virginia	.35
25. Montana	.50	49. California	.20
		50. District of Columbia	.17



Exhibit 4-20

Average Annual Cost Per Recipient of Intermediate Care Facility for the Mentally Retarded (ICF-MR), Intermediate Care Facility (ICF), and Skilled Nurses Facility (SNF), Care, by State: 1982 1082 Data

	<u>ICF-MR</u>	<u>ICF</u>	<u>SNF</u>	<u>All</u>
Alabama	\$20,256	\$ 5,939	\$ 3,042	\$ 6,295
Alaska	38,079	14,132	8,982	16,300
Arkansas	23,715	5,213	5,151	6,310
California	12,545	2,459	5,236	5,222
Colorado	20,653	5,979	4,930	7,348
Connecticut	26,591	5,867	9,982	10,391
Delaware	17,390	10,812	1,852	11,876
D.C.	11,827	10,804	5,132	9,740
Florida	10,489	5,441	4,218	5,598
Georgia	28,378	5,789	4,684	6,399
Hawaii	24,936	12,506	10,634	12,804
Idaho	27,900	6,659	4,739	8,430
Illinois	18,104	5,389	5,446	6,734
Indiana	17,160	6,844	*	7,615
Iowa	30,390	5,055	6,398	7,068
Kansas	18,327	4,737	1,843	6,185
Kentucky	20,748	5,981	5,039	6,770
Louisiana	24,052	6,799	5,628	9,163
Maine	24,212	8,140	3,163	8,715
Maryland	24,420	8,202	*	9,877
Massachusetts	47,790	8,312	9,602	11,591
Michigan	34,151	6,517	4,684	7,896
Minnesota	20,944	5,937	8,985	9,405
Mississippi	12,976	6,205	6,229	6,766
Missouri	17,145	6,779	1,707	7,376
Montana	18,847	6,961	4,390	7,275
Nebraska	20,775	5,081	6,387	6,635
Nevada	26,959	8,578	3,465	9,198
New Hampshire	19,997	9,755	3,083	9,968
New Jersey	25,427	8,858	4,525	10,693
New Mexico	20,104	6,363	5,337	8,178
New York	25,478	8,225	15,539	15,982
North Carolina	29,762	6,786	6,497	8,805
North Dakota	11,362	5,360	7,583	6,566
Ohio	18,062	6,644	6,594	7,728
Oklahoma	18,128	6,319	*	7,176
Oregon	15,616	4,994	2,488	5,434
Pennsylvania	46,535	10,927	11,152	15,655
Rhode Island	36,820	9,394	2,027	11,058
South Carolina	13,896	7,332	6,987	8,147
South Dakota	18,270	5,552	3,290	6,914
Tennessee	22,094	5,903	2,789	6,784
Texas	16,912	4,852	3,798	6,406
Utah	16,381	6,755	4,839	8,449
Vermont	41,085	7,965	5,155	11,856
Virginia	17,743	8,701	5,223	10,169
Washington	26,244	5,931	7,055	9,321
West Virginia	6,493	5,699	*	5,714
Wisconsin	26,167	6,078	6,502	7,029
Wyoming	0	7,339	6,547	7,218
U.S.	\$23,435	\$ 6,499	\$ 7,855	\$ 8,775

\*No expenditure for SNF Care

#### 4.3.1 Person-based Data on Institutionalized Recipients in Michigan and New York

Perhaps the richest source of data becoming available on institutionalized Medicaid recipients is the Tape-to-Tape data base. Early Returns Tables for two of the five Tape-to-Tape States (New York and Michigan) have recently become available. These tables include extensive cross-tabulations on the characteristics and utilization patterns of institutionalized recipients. Since Tape-to-Tape files are constructed at the person-based level, this data base holds the potential for extremely detailed analyses of the institutionalized population.

Two important capabilities of the Tape-to-Tape data base are: (1) the ability to calculate expenditures by person-years of enrollment rather than by the number of recipients, and (2) the ability to track total Medicaid expenditures for each recipient across all services. The former ability is important because statistics relating costs per recipient are somewhat misleading. Due to turnover among Medicaid enrollees, statistics reporting costs per recipient substantially underestimate the costs of enrollment changes in the Medicaid program. Recipients who leave the program on January 1 or who enter the program on December 31 are still counted as recipients along with persons who are enrolled for the entire year, effectively bringing down average costs per recipient. Since the Tape-to-Tape data base tracks enrollment dates as well as Medicaid claims, it has the capability to adjust expenditure data to reflect average costs per person-year of Medicaid enrollment.

When institutional care costs are adjusted from costs per recipient to costs per person-year of enrollment, average expenditures increase significantly (Exhibit 4-21). In Michigan, average costs for the disabled increased 8%, and for the aged, 20%. The New York institutionalized population had higher turnover rates, and therefore even higher cost differentials. Expenditures for the disabled in New York increased by 22% when adjusted to a person-year of enrollment basis, and for the aged, 36%.

The second capability of Tape-to-Tape -- the ability to track total Medicaid expenditures by type of service -- is also important to the analysis of the nursing home population, since nursing home recipients incur costs over and above long-term care claims (e.g., physician costs, hospitalization costs, etc.). In computing the real costs of serving the nursing home population, these additional costs should be taken into account.

Total Medicaid costs for institutionalized recipients in Michigan and New York are presented in Exhibit 4-22. In both States, disabled institutionalized recipients were higher utilizers of services other than nursing home care than aged recipients.

Exhibit 4-21

Average Nursing Home Costs Per Recipient and Per Person-Year of Enrollment for Institutionalized Recipients:\* New York and Michigan 1981 Tape-to-Tape Data

	<u>Average Months of Enrollment in 1981</u>	<u>(1) Costs Per Recipient</u>	<u>(2) Costs Per Person- Year of Enrollment</u>	<u>(2) / / (1)</u>
<u>Michigan</u>				
Aged	10.0 months	\$5,864	\$7,017	1.20
Disabled	11.1 months	\$11,599	\$12,573	1.08
<u>New York**</u>				
Aged	8.8 months	\$13,667	\$18,585	1.36
Disabled	8.2 months	\$18,508	\$22,511	1.22

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\* The Tape-to-Tape data files include recipients of inpatient psychiatric services in its definition of the institutionalized population.

\*\* New York Tape-to-Tape data on average length of enrollment may underestimate actual length of enrollment due to the inclusion of only partial-year data in some counties for 1981, attributable to the phase-in of the New York MMIS during that year. New York Tape-to-Tape files also do not include recipients of ICF-MRS which are publicly-owned (the majority of ICF-MR recipients).

Exhibit 4-22

Average Total Medicaid Expenditures Per Person-Year of Enrollment for Institutionalized and Non-Institutionalized Aged and Disabled Recipients by Summary Service Category: 1981 New York and Michigan Tape-to-Tape Data

Costs Per Person-Year of Enrollment

Summary Service Category	New York		Michigan	
	Non-Institutionalized Recipients	Institutionalized Recipients	Non-Institutionalized Recipients	Institutionalized Recipients
<u>Inpt. Hospital</u>				
Aged	\$597	\$767	\$171	\$104
Disabled	1,404	2,369	1,262	1,132
<u>Long-Term Care</u>				
Aged	-	18,585	-	7,017
Disabled	-	22,511	-	12,573
<u>Other Services</u>				
Aged	799	268	438	457
Disabled	1,138	1,143	852	828
<u>Total</u>				
Aged	1,396	19,620	608	7,578
Disabled	2,542	26,023	2,114	14,533



These additional service costs increased total average costs for disabled recipients in both States by 15.6%. In New York, average costs for aged institutionalized recipients increased by 6% when hospital and other service costs are added, while in Michigan costs increased 8% for aged institutionalized recipients. If these ratios are applied to the entire institutionalized Medicaid population, it is estimated that institutionalized recipients account for 48% of all Medicaid expenditures (as opposed to 43% when only long-term care claims are counted).

#### 4.4 Summary

The Medicaid nursing home population increased by 12% between 1975 and 1982, despite a 1% decline in the total Medicaid recipient population over the same period. The aged nursing home population increased by about 11% while the total aged recipient population declined 7.5%. The number of aged nursing home recipients grew at a slower rate than the entire elderly population, but at a faster rate than the elderly population below poverty level (Exhibit 4-23).

The institutionalized disabled population grew by 33% between 1975 and 1982, more than three times the rate of growth of the aged institutionalized population. The proportion of all institutionalized Medicaid recipients who were disabled has increased from 22% to 26% over this period.

Exhibit 4-23

#### Growth in the Aged Medicaid Nursing Home Population in Comparison to other Populations: 1975-1982

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	<u>Percent Change 1975-1982</u>
Aged Medicaid Nursing Home Recipients	+10.9%
Total Aged Medicaid Recipients	-7.5
Total U.S. Elderly Population	+19.6
Total U.S. Elderly Population Below Poverty Level	+8.0

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Since 1975, expenditures for nursing home care have been rising at an annual compound rate of 15.7% in comparison to 13.5% for all Medicaid services. Up until 1980, this greater rate of growth was attributable to the growing number of persons receiving nursing home care, while the non-institutionalized Medicaid population was declining. Since 1980, however, the greater rate of growth for nursing home care is primarily attributable to the fact that average

costs per nursing home recipient have been rising faster than average costs for non-institutionalized recipients. Even though enrollment data indicate that the Medicaid nursing home population declined by 125,000 recipients between 1981 and 1982, or 8%, the growth in nursing home expenditures still outpaced expenditure increases for other Medicaid services. These data suggest that the case mix of the Medicaid nursing home population is becoming more severely disabled, and consequently more costly to serve. This conclusion is supported by empirical data from at least one State, Minnesota, as cited in the recent GAO report. Rapidly rising costs for ICF-MR care, which averaged \$23,435 per recipient in 1982, are another factor contributing to the continued growth in nursing home expenditures.

## Chapter 5

### DUAL ENROLLEES

Policymakers' interests have recently focused on a special subset of Medicaid enrollees who are dual enrollees -- individuals enrolled in both Medicare and Medicaid. Their eligibility for Medicare indicates that they are either aged or disabled. Their eligibility for Medicaid indicates that they are also "needy," according to the financial requirements of their States' Medicaid programs.

Medicare and Medicaid share the health care costs of dual enrollees in a special way. Medicare is the first payor for those services covered by both Medicare and Medicaid. Medicaid, in turn, generally pays the cost-sharing requirements imposed on Medicare enrollees, and also pays for those services covered only by Medicaid.

Dual enrollees are interesting to policymakers because they form a link through which changes in one health insurance program may effect changes in the other. For example, increased cost-sharing provisions in Medicare can shift health care costs for dual enrollees from Medicare to Medicaid. In addition, policymakers are concerned that the introduction of a hospital prospective payment system into Medicare may lead to increased costs for all other payors, including Medicaid. Policymakers are especially concerned about cost shifting from Medicare to Medicaid because they suspect dual enrollees to be relatively frequent and costly users of health care.

States, in particular, may have a special interest in observing expenditures for dual enrollees, because they have the option of "buying-in" Medicare Supplementary Insurance (Part B) for many of their aged and disabled Medicaid enrollees. When a State "buys-in" Medicare Part B coverage for its eligible Medicaid enrollees, Medicare becomes the first payor for a range of physician,

outpatient, home health, and other services. In return, the State Medicaid program pays the Part B premiums, deductibles, and coinsurance for these services, even if not all of these services are included in the State's Medicaid plan. As a result, buying-in may significantly alter the share of health care costs borne by Medicaid. In fact, the analysis included in this chapter suggests States may realize substantial savings by buying-in their Medicaid enrollees who are eligible for (but not enrolled in) Medicare.

Finally, dual enrollees offer analysts a unique opportunity to look at total health expenditures for a major subset of the Medicaid population. By looking at both Medicare and Medicaid program data, analysts can identify the relative importance of Medicaid expenditures in the overall health care costs of these aged and disabled individuals.

This chapter is organized to address policymakers' key interests regarding dual enrollees. Section 5.1 begins with a brief discussion of the various data sources and definitions used in this chapter. It is intended to provide a consistent set of terms across different data sources and programs. Section 5.2 follows with a profile of dual enrollees, and looks at aged and disabled dual enrollees separately, discussing their characteristics, utilization rates, and expenditures. This section attempts to determine whether dual enrollees are, in fact, extremely frequent or costly users of health care. Section 5.3 then reviews State buy-in decisions in some detail, and assesses whether States win or lose by buying-in their dual eligibles on Medicaid. The final section, 5.4, is a brief summary section, highlighting the major findings and conclusions from this analysis of dual enrollees.

It should be noted that much of the analysis in Section 5.2 draws heavily upon research conducted by others. For example, much of the discussion of aged dual enrollees is based on a recently published article by Alma McMillan, Penelope Pine, Marian Gornick, and Ronald Prihoda, "A Study of the 'Crossover Population': Aged Persons Entitled to Both Medicare and Medicaid," Health Care Financing Review, Summer 1983. McMillan and Pine also specified several tables used in the analysis of disabled dual enrollees. In addition, several researchers wrote papers using 1980 NMCUES data -- papers which provided much of the information on utilization and expenditures by dual enrollees. These papers are cited in each exhibit.

## 5.1 Data and Definitions

In theory, dual enrollees are an easy group to identify: they are those individuals simultaneously enrolled in both Medicare and Medicaid. In practice, however, dual enrollees have proven



extremely difficult to identify. Currently available data bases generally identify only subsets of dual enrollees -- subsets which, unfortunately, vary across data bases.

As a result, several terms have emerged from existing data and the literature to describe various groups of dual enrollees. These terms have not always been applied consistently across data bases or reports. For the sake of clarity, the following terms were used in this chapter to distinguish different groups of dual enrollees from one another:<sup>34</sup>

- Dual enrollees: those individuals simultaneously enrolled in both Medicare and Medicaid. Although this is the group of primary interest to policymakers, no existing data base identified this group. (Note that dual enrollees are a subset of dual entitlees, individuals eligible for both Medicare and Medicaid but not necessarily enrolled in both simultaneously.)
- Buy-ins: the subset of dual enrollees for whom States purchased or "bought-in" Medicare Part B coverage. It included both recipients and non-recipients of health care. (It excluded those dual enrollees who purchased their own Medicare Part B coverage.)
- Cross-over Recipients: the subset of dual enrollees who received services financed by both Medicare and Medicaid, i.e., for whom both Medicare and Medicaid claims were processed. (It excluded those dual enrollees who had claims processed under only one program, and those who received no services under either program.)

Unfortunately, no existing data base described the population of primary interest to policymakers -- all dual enrollees. Four data bases did, however, provide useful information on different subsets of dual enrollees:

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<sup>34</sup>Some readers may find these terms slightly confusing, because they are sometimes used in existing literature in different ways. McMillan, et al., for example, in a recent article published in the Health Care Financing Review used the term "cross-overs" to describe the group termed "buy-ins" in this chapter. In contrast, analysts using data from the Tape-to-Tape system use the term "cross-over" to describe the group termed "cross-over recipients" in this chapter.

- Continuous Medicare History Survey (CMHS): a 5% systematic sample derived from the Medicare Statistical System. It identified buy-ins<sup>35</sup> enrolled in Medicare as of July 1, 1978. "Non-buy-ins" were defined as the rest of the Medicare population, and included dual enrollees who purchased their own Medicare Part B coverage. (Note that the CMHS includes both the institutionalized and the non-institutionalized.)
- National Medical Utilization and Expenditure Survey (NMCUES): a special data base including a national household sample and a 4-state sample of Medicaid households. The national household sample was most useful for this chapter, and identified only non-institutionalized dual enrollees by person-years of enrollment in 1980.
- New York Tape-to-Tape: derived from the State's MMIS data. It identified cross-over recipients by person-years of Medicaid enrollment in 1980 and 1981. (Note that Tape-to-Tape also describe both the institutionalized and non-institutionalized.)
- HCFA 120/2082: derived from monthly and annual State Medicaid reporting forms. These data did not identify individuals who were dual enrollees (the data were not person-based), but did describe aggregate premium, coinsurance, and deductible payments made by Medicaid to Medicare on behalf of buy-ins and cross-over recipients in 1978.

In spite of the fact that these data bases described different subsets of dual enrollees, the findings presented in this chapter were usually generalized to all dual enrollees. Specific references to different subsets, such as buy-ins or cross-over recipients, were avoided in order to make the analysis more readable. Such generalizations may, perhaps, be misleading to the extent they ignore important differences between the various subsets of dual enrollees. On the other hand, these generalizations are useful in

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<sup>35</sup>The CMHS data used in this report identified the subset of buy-ins who were enrolled in both Part A and Part B under Medicare. This subset was a fairly large subset of buy-ins, however; McMillan, et al. estimated that 96% of all buy-ins had coverage under both Parts A and B.

that they represent "best guesses" about the composition and behavior of all dual enrollees.

Specific references were made to only one subset of dual enrollees -- buy-ins -- in the last section on State buy-in decisions. The distinction between buy-ins and other dual enrollees was especially important in this section, because it reflected the restrictiveness of State buy-in agreements: the more restrictive the buy-in agreement, the greater the difference between buy-ins and all dual enrollees.

A special set of definitions was also constructed to clarify comparisons between Medicare and Medicaid data. Because the Medicare and Medicaid programs employed somewhat different terms to describe program enrollees, recipients, and expenditures, the following definitions were applied throughout this chapter:

- Enrollees/Beneficiaries: the unduplicated total number of persons enrolled in Medicaid or Medicare, including both recipients and non-recipients of health care services.
- Recipients (Users): the unduplicated total number of persons who received at least one unit of service from either Medicaid or Medicare.
- Recipient (User) rates: the proportion of enrollees who were recipients. Usually expressed as the number of recipients per 1,000 enrollees.
- Utilization rates: the number of service units used (e.g., visits, discharges, days of care). Usually expressed per 1,000 enrollees.
- Expenditures/Reimbursements: health care costs incurred by individuals and paid for by either the individuals, Medicare, Medicaid, or a third party.

These terms generally correspond to Medicaid definitions and may therefore be confusing to readers familiar only with Medicare. Medicare, for example, generally applies the term "beneficiary" to describe both enrollees and recipients. But because this report is focused on Medicaid evaluation issues, terms consistent with Medicaid terms were applied throughout this chapter.

## 5.2 Describing Dual Enrollees

People can become dual enrollees in a variety of ways. Most aged Medicaid enrollees, for example, qualify for Medicare by virtue of their age and Social Security status. Alternatively, some aged Medicare enrollees may qualify for Medicaid due to extremely high medical expenses or low Social Security benefits which make them "needy" by Medicaid standards.



Similarly, disabled Medicaid enrollees may qualify for Medicare by virtue of their disability and Social Security status. But they face an additional hurdle not faced by the aged: they must either qualify for or receive Social Security disability benefits for at least two years before they are eligible for Medicare. Disabled Medicare enrollees, in turn, may qualify for Medicaid if their medical expenses are extremely high or their incomes are extremely low.

In theory, dual enrollees are easy to identify. In practice, they are extremely difficult to count. Best estimates of the national dual enrollee population -- aged and disabled combined -- are derived from CMHS data. They indicate that dual enrollees numbered 3.3 million in 1978, accounting for roughly 12% of the Medicare Part B population<sup>36</sup> and 15% of the Medicaid population. Exhibit 5-1 illustrates the dual enrollees' shares of Medicare and Medicaid in 1978.

Although dual enrollees formed only small shares of Medicare and Medicaid enrollment, they formed larger shares of total program expenditures. (This is probably not all that surprising, since dual enrollees are either aged or disabled.) For example, while dual enrollees accounted for 12% of Medicare Part B enrollment in 1978, they accounted for 18% of Medicare Part B expenditures. Corresponding data on national Medicaid enrollment and expenditures were not available, but in New York, limited Tape-to-Tape data revealed that dual enrollees contributed 15% of enrollment and 48% of expenditures in 1981.

At least some of these relatively high expenditures by dual enrollees were driven by high utilization rates among dual enrollees. NMCUES data describing the first six months of 1980, for example, revealed that dual enrollees were much more frequent users of almost all types of health care than other Medicare or Medicaid populations. The data summarized in Exhibit 5-2 show that dual enrollees were far more frequent users of inpatient hospital care, ambulatory care, and prescription drugs than other Medicare and other Medicaid enrollees. There was only one exception to this pattern of frequent use: dual enrollees were the lowest users of dental care.

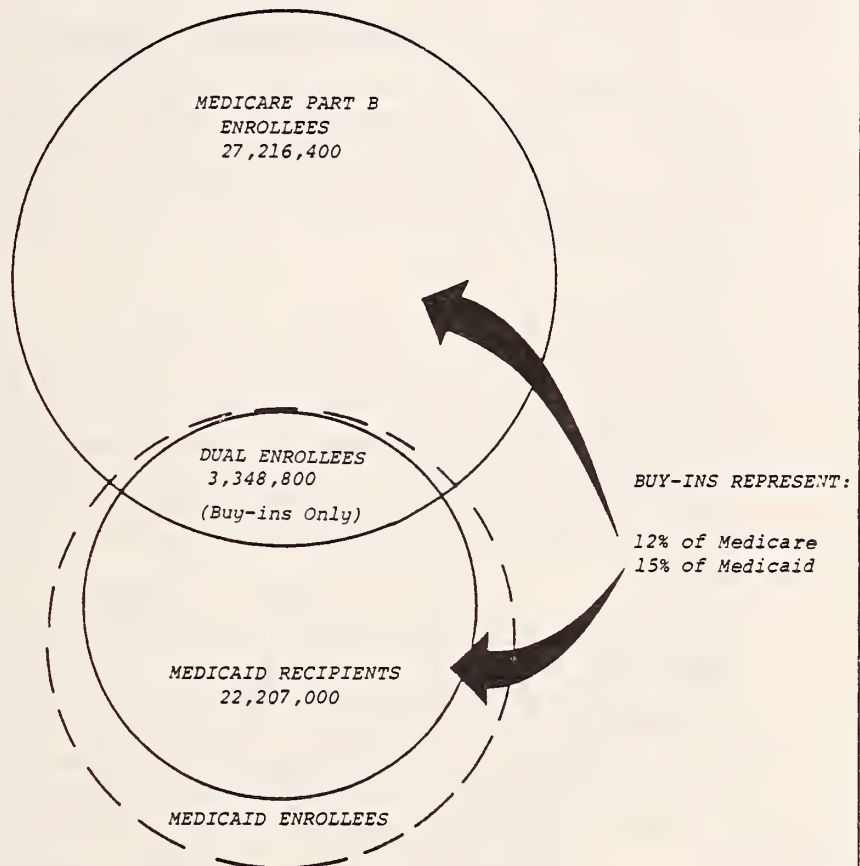
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<sup>36</sup>CMHS data compared dual enrollment only to Medicare Part B enrollment. It excluded those Medicare enrollees who had only Part A coverage.



Exhibit 5-1

National Medicare\*, Medicaid, and Dual Enrollee Populations, 1978  
(Including both the aged and the disabled)



\* Excludes Medicare enrollees with only Part A coverage.

NOTE: These circles are not drawn precisely to scale.

Sources: Medicare and buy-in statistics from CMHS (1978) data published by Mcmillan, Alma; Pine, Penelope L.; Gornick, Marian; and Prihoda, Ronald, "A Study of the 'Crossover Population': Aged Persons Entitled to Both Medicare and Medicaid," Health Care Financing Review, Summer 1983, vol. 4, no. 4. Also from unpublished CMHS (1978) tables specified by McMillan and Pine. Medicaid statistic from HCFA 2082 (1978) data published in the Health Care Financing Review, op. cit.

Exhibit 5-2

Selected Six-Month Utilization Rates for All Health Care  
for Non-institutionalized Dual Enrollees and  
Other Non-institutionalized Health Insurance Groups, 1980  
(Aged and Disabled Combined)

Health Insurance Group Utilization Measure per 1,000 enrollees **	Dual Enrollees	Medicare- Only	Medicaid- Only	Other Coverage	No Coverage
INPATIENT CARE					
• discharges	290	165	113	69	64
• length of stay (days)	12.6	11.3	6.4	6.9	6.3
• days of care	3,671	1,864	722	474	403
DOCTOR CARE					
• total visits	5,146	3,210	2,565	1,975	1,416
• visits: doctor seen	3,879	2,701	2,368	1,662	1,221
•• specialist seen	1,239	1,298	1,188	897	470
•• general practit. seen	2,318	1,283	917	625	618
•• office visit	2,637	1,908	1,237	1,148	745
•• hospital outpatient	423	326	341	150	147
•• emergency room	322	120	263	140	133
•• other location	496	347	526	224	196
• visits: doctor not seen	1,267	509	197	313	195
OTHER CARE					
• dental	308	540	500	852	376
• medicine	7,419	5,309	2,061	1,785	1,267

\* Note that these are only six-month rates, not annual rates. Data used for this table did not separate the aged from the disabled, and covered only the first six months of 1980. Twelve-month data were not available in time for this report.

\*\* Except for "length of stay," which is an average, not a rate.

Source: NMCUES (1980) data reported by Dobson, Allen; Scharff, Jack; and Corder, Larry, "Analysis of the First Six Months of Medicaid Data from the National Medical Care Utilization and Expenditure Survey: The First Annual NMCUES Medicaid Report," September 1982 (the unpublished version).

Unfortunately, these particular data provided only part of the story behind high utilization rates and high expenditures. They did not, for example, distinguish between aged and disabled dual enrollees -- two groups with extremely different age compositions and health conditions.

The rest of this section therefore describes aged and disabled dual enrollees separately, comparing the characteristics, utilization rates, and expenditures of each to those of other Medicare and Medicaid enrollees.

#### 5.2.1 Aged Dual Enrollees: Characteristics

Aged dual enrollees numbered 2.8 million in 1978, composing roughly 11% of aged Medicare Part B enrollment nationwide. This proportion varied dramatically across States, ranging from a low of 2.5% in New Hampshire to a high of 31.2% in Mississippi. State-by-State aged dual enrollee shares of Medicare enrollment are presented in Exhibit 5-3.

Such variation in the share of Medicare enrollment formed by aged dual enrollees may have been due, in part, to two factors: (1) the restrictiveness of Medicaid eligibility criteria in each State, and (2) the restrictiveness of buy-in agreements in each State. In States with very restrictive Medicaid eligibility criteria, many aged Medicare beneficiaries might not have qualified for Medicaid. Similarly, in States with very restrictive buy-in agreements, some aged Medicaid enrollees might not have acquired Medicare.<sup>37</sup>

As a group, aged dual enrollees were older, with disproportionately more women and minorities than the rest of the aged Medicare population. Exhibit 5-4 presents the age, race, and sex composition of aged dual enrollees and aged Medicare-only enrollees. Roughly 57% of aged dual enrollees were 75 and older, compared to 38% of aged Medicare-only enrollees. 68% of dual enrollees were female, compared to 59% of aged Medicare-only enrollees. And 24% of aged dual enrollees were non-white, compared to 9% of aged Medicare-only enrollees. Such compositional differences were not, however, surprising, since they were consistent with widely held notions of how the elderly poor and

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<sup>37</sup>This may be an especially important factor in explaining the variation in proportions described in Exhibit 5-4, since these data referred to the proportion of Medicare Part B enrollees who were buy-ins.

Aged Dual Enrollees as a Percentage of Aged Medicare Part B Enrollment,  
by State: 1978

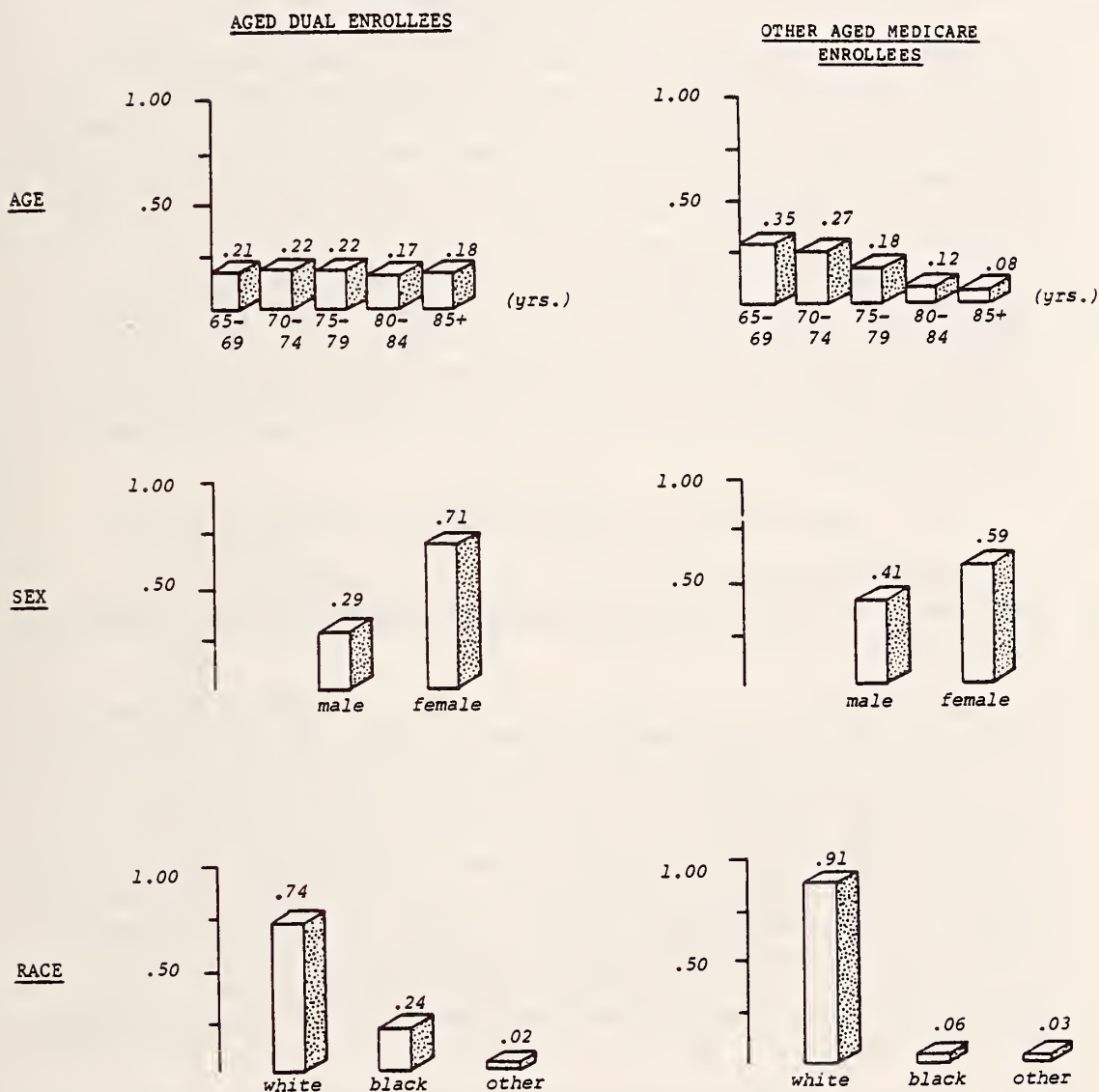
STATE	Total Aged Part B Enrollment (000)	Total Aged Dual Enrollees (000)	Aged Dual Enrollees as % of Part B Enrollment
U.S. TOTAL	24,703.7	2,818.6	11.4%
Alabama	420.8	117.3	27.9%
Alaska	8.7	0	0%
Arizona	-----	NO MEDICAID PROGRAM	-----
Arkansas	300.1	72.8	24.3%
California	2,300.5	513.6	22.3%
Colorado	237.4	32.2	13.6%
Connecticut	358.6	8.6	2.4%
Delaware	57.9	3.8	6.6%
D.C.	68.5	13.1	19.1%
Florida	1,495.4	126.9	8.5%
Georgia	486.1	117.5	24.2%
Hawaii	68.2	9.7	14.2%
Idaho	90.6	6.4	7.1%
Illinois	1,245.0	48.1	3.9%
Indiana	578.7	33.6	5.8%
Iowa	392.6	32.2	8.2%
Kansas	306.8	26.7	8.7%
Kentucky	403.4	62.3	15.4%
Louisiana	364.0	0	0%
Maine	142.4	14.6	10.3%
Maryland	368.5	42.1	11.4%
Massachusetts	718.6	89.6	12.5%
Michigan	911.4	59.9	6.6%
Minnesota	480.9	16.6	3.5%
Mississippi	277.8	86.6	31.2%
Missouri	643.2	65.6	10.2%
Montana	84.1	7.9	9.4%
Nebraska	207.7	6.6	3.2%
Nevada	57.4	4.6	8.0%
New Hampshire	101.4	2.5	2.5%
New Jersey	850.1	65.5	7.7%
New Mexico	106.7	16.8	15.7%
New York	2,160.1	204.3	9.5%
North Carolina	568.1	84.4	14.9%
North Dakota	81.4	4.0	4.9%
Ohio	1,154.2	83.3	7.2%
Oklahoma	360.0	44.9	12.5%
Oregon	288.2	0	0%
Pennsylvania	1,507.5	85.1	5.6%
Rhode Island	124.6	9.0	7.2%
South Carolina	266.6	61.1	22.9%
South Dakota	91.7	5.9	6.4%
Tennessee	495.1	85.9	17.4%
Texas	1,297.4	250.9	19.3%
Utah	101.5	6.3	6.2%
Vermont	58.7	5.4	9.2%
Virginia	472.0	61.0	12.9%
Washington	411.9	42.9	10.4%
West Virginia	233.6	22.2	9.5%
Wisconsin	568.3	42.2	7.4%
Wyoming	37.1	0	0%

Source: CMHS (1978) data published by McMillan, et al., Health Care Financing Review, op. cit.



Exhibit 5-4

Age, Sex, and Race Composition of Aged Dual Enrollees and Other Aged Medicare Enrollees, 1978



Source: CMHS (1978) data as published by Mcmillan, et al., Health Care Financing Review, op. cit.

non-poor compare: the elderly poor are generally older, with disproportionately more women and minorities than the elderly non-poor.

Aged dual enrollees also appeared to have poorer health than their counterparts with only Medicare coverage. Aged dual enrollees, for example, had age-adjusted death rates 53% higher than other aged Medicare enrollees in 1978. In addition, 55% of aged dual enrollees reported their health as fair or poor, compared to 37% of all aged Medicare beneficiaries. Health status and death rates for aged dual enrollees are presented in Exhibit 5-5.

There were ample data in the CMHS and NMCUES data bases to describe differences between aged dual enrollees and their Medicare-only counterparts. It was, however, virtually impossible to compare aged dual enrollees to their Medicaid-only counterparts. This was probably due to the fact that there were very few aged Medicaid-only enrollees at any point in time; most aged Medicaid enrollees qualified for Medicare by virtue of their age and Social Security coverage. In New York, for example, dual enrollees accounted for 77% of aged Medicaid enrollment and 90% of aged Medicaid recipients in 1981. Thus, most data did not describe the relatively small aged Medicaid-only population. Exhibit 5-6 illustrates aged dual enrollee shares of aged Medicare and aged Medicaid enrollment nationwide for 1978 (as derived from CMHS and HCFA 2082 data).

#### 5.2.2 Aged Dual Enrollees Utilization and Expenditures

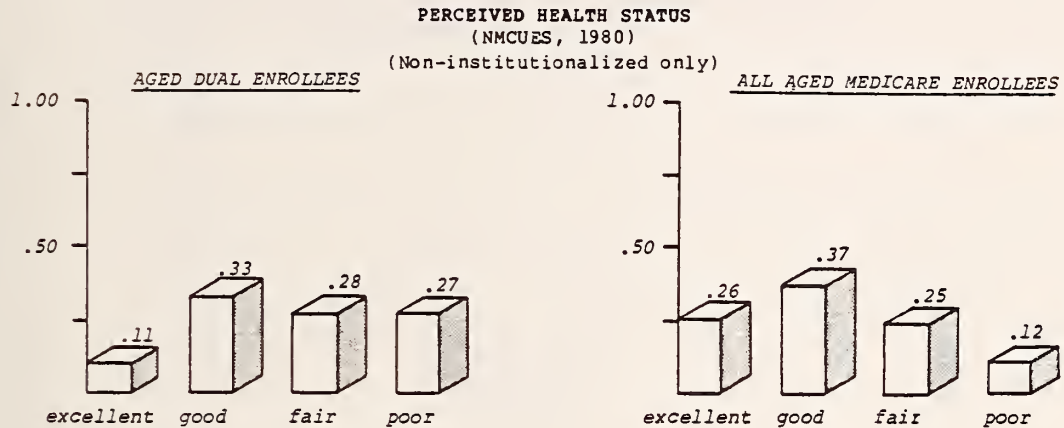
Compared to other aged users of health care, aged dual enrollees were clearly among the most frequent and costly users of health care.

In the Medicare program, for example, aged dual enrollees had Medicare reimbursements per enrollee which were 60% higher than those for aged Medicare-only enrollees (see Exhibit 5-7). Part of the difference between dual enrollees and other aged Medicare enrollees was probably due to age. But even after adjusting for differences in age, aged dual enrollees had disproportionately high expenditures and utilization rates. For example, age-adjusted reimbursements per enrollee were 50% higher for dual enrollee than for other aged Medicare enrollees. Age adjusted recipient rates were also dramatically higher for dual enrollees in each major service category, ranging from 30%-100% above rates for other aged Medicare enrollees.

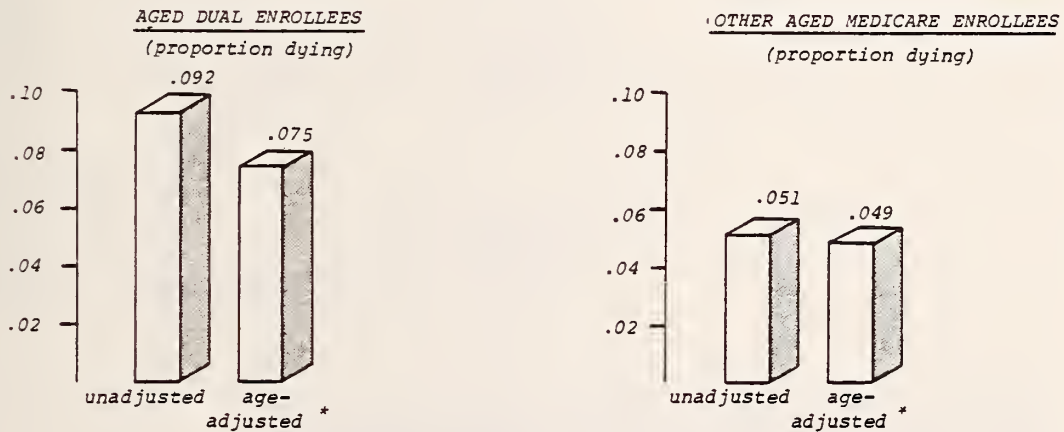
In addition to having disproportionately high utilization rates, aged dual enrollees also incurred higher Medicare costs per recipient than other aged Medicare enrollees. Medicare data in

Exhibit 5-5

Health Status, 1980, and Death Rates, 1978, for Aged Dual Enrollees and Aged Medicare Comparison Groups



**DEATH RATES**  
(CMHS, 1978)

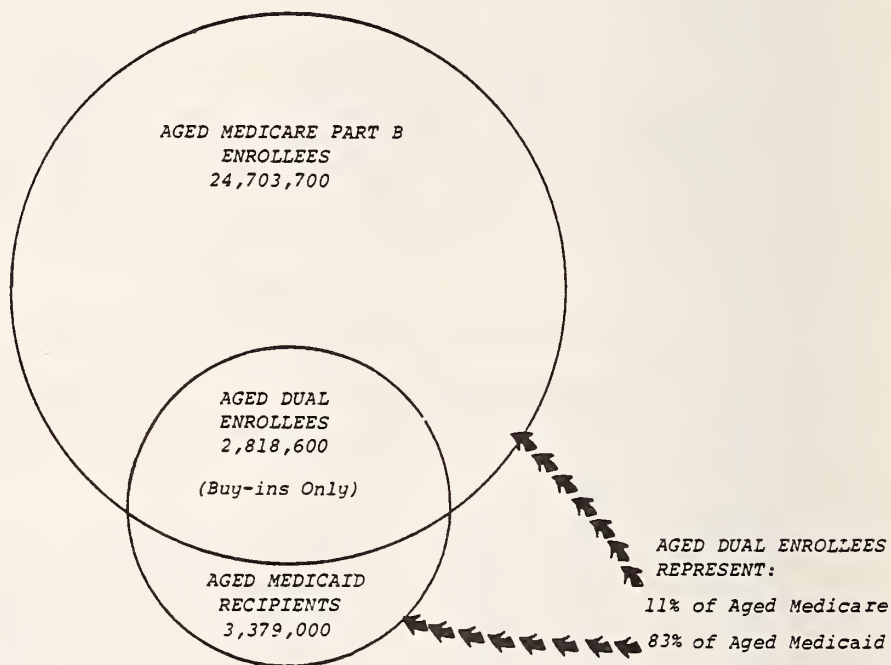


\* Adjusted to correspond to the age profile of the total aged Medicare population.

Sources: NMCUES (1980) data reported by Garfinkel, Steven A. and Corder, Larry S. in "The Use of Supplemental Health Insurance Plans by Aged Medicare Beneficiaries," April 1983 (unpublished). Also CMHS (1978) data published by Mcmillan, et al., Health Care Financing Review, op. cit.

Exhibit 5-6

Aged Dual Enrollees and Their Shares of Aged Medicare and  
Medicaid Enrollment: 1978



Sources: Medicare and buy-in statistics from CMHS (1978) data published by McMillan, et al., Health Care Financing Review, op. cit. Medicaid statistic from HCFA 2082 (1978) data published in the Health Care Financing Review, op. cit.



Exhibit 5-7

Medicare Reimbursement and Utilization Rates for Aged Dual Enrollees and Other Aged Medicare Enrollees: 1978

	Aged Dual Enrollees		Other Aged Medicare Enrollees		RATIO:	
	Unadjusted	Age-Adjusted	Unadjusted	Age-Adjusted	Dual Enrollees to Other Enrollees	Unadjusted Age-Adjusted
• reimbursements/enrollee						
- Part A	\$914	\$879				
- Part B	\$369	\$368	\$562	\$570	1.6	1.5
• recipients/1000 enrollees						
- Part A	320	306	220	222	1.5	1.4
- Part B	756	741	577	580	1.3	1.3
• recipients/1000 enrollees (by services)						
- Part A: Inpatient Hospital	315	302	217	220	1.5	1.4
- Part A: SNF	16	13	7	8	2.3	1.6
- Part A: Home Health	38	36	21	21	1.8	1.7
- Part B: Physician	721	704	552	555	1.3	1.3
- Part B: Other Medical	280	258	149	151	1.9	1.7
- Part B: Outpatient	333	336	214	215	1.6	1.6
- Part B: Home Health	20	18	9	9	2.2	2.0
• hospital discharges/1000 enrollees	498	481	315	319	1.6	1.5
• reimbursements/recipient						
- Part A	\$2,861	\$2,878	\$2,560	\$2,538	1.1	1.1
- Part B	\$488	\$498	\$411	\$410	1.2	1.2

Source: CMHS (1978) data published by McMillan, et al., Health Care Financing Review, OP. cit.

Exhibit 5-7 indicate that aged dual enrollees had Medicare reimbursements per recipient 10%-20% higher than the aged Medicare-only population.

Looking beyond those services covered only by Medicare to all health care services, aged dual enrollees were the highest users of inpatient and ambulatory care among all other aged groups observed. 1980 NMCUES data, summarized in Exhibit 5-8, indicate that aged dual enrollees had higher inpatient and ambulatory utilization rates than aged Medicare-only beneficiaries with private insurance (who were 2nd), aged Medicare-only beneficiaries with no other insurance (who were 3rd), and other aged individuals with no Medicare coverage at all.

Aged dual enrollees were particularly high users of inpatient care, with hospital discharge and total hospital day rates 90%-270% higher than the other aged groups surveyed. But aged dual enrollees' average length of stay varied from 10% below to 10% above the average length of stay of other groups. In other words, aged dual enrollees went to the hospital far more frequently than other aged groups, but once there, stayed for roughly comparable lengths of time.

Aged dual enrollees were also the highest users of ambulatory care, but the differences between dual enrollees and other aged groups were somewhat smaller than those found in inpatient care. Ambulatory and physician rates for aged dual enrollees were 20%-150% higher than those for other aged groups.

More detailed NMCUES utilization data presented in Exhibit 5-9 reveal that these especially high utilization rates for aged dual enrollees were the result of two factors: (1) aged dual enrollees had disproportionately more users than the other aged groups, and (2) aged dual enrollees had disproportionately more "high users" than the other aged groups.

Given these especially high utilization rates for aged dual enrollees, it was not surprising to find that aged dual enrollees incurred total health care costs per capita which were 80%-180% higher than those of other aged Medicare beneficiaries. In 1980, non-institutionalized aged dual enrollees incurred annual total health care costs of \$3,106 per capita, compared to \$1,767 for aged Medicare-only beneficiaries with private coverage and \$1,104 for aged Medicare-only beneficiaries without private coverage.

But in spite of their higher total expenditures, aged dual enrollees faced much lower out-of-pocket expenditures per capita than other aged groups. In 1980, aged dual enrollees spent an average of \$233 per year out-of-pocket, while aged Medicare-only beneficiaries with private coverage spent \$352 and aged Medicare-only beneficiaries without private coverage spent \$319.

Exhibit 5-8

Selected Utilization Rates for Non-Institutionalized Aged Dual Enrollee and Other Non-Institutionalized Aged Groups: All\* Inpatient and Ambulatory Services: 1980

	Aged Dual Enrollees	Aged Medicare-Only W/No Private	Aged Medicare-Only Plus Private	Aged Without Medicare
INPATIENT HOSPITAL CARE				
• Discharges/1000 persons	706	248	370	220
• Total days of care/ 1000 persons	8,044	2,968	3,734	2,202
• Average length of stay (days)	11.39	11.99	10.08	10.01
AMBULATORY CARE				
• Ambulatory visits/person	11.05	5.64	9.12	4.41
• Physician visits/person	9.15	4.39	7.05	4.09

Ratio of Aged Dual Enrollee Utilization Rates to Other Group Rates

	Aged Medicare-Only W/No Private	Aged Medicare-Only Plus Private	Aged Without Medicare
INPATIENT HOSPITAL CARE			
• Discharges/1000 persons	2.8	1.9	3.2
• Total days of care/ 1000 persons	2.7	2.2	3.7
• Average length of stay (days)	0.9	1.1	1.1
AMBULATORY CARE			
• Ambulatory visits/person	2.0	1.2	2.5
• Physician visits/person	2.1	1.3	2.2

\*Not limited to services paid for by Medicare.

NOTE: Persons defined as person-years of enrollment.

Source: NMCUES (1980) data reported by Garfinkel, Steven A.; Corder, Larry S; and Dobson, Allen, "Health Services Utilization in the U.S. Population by Health Insurance Coverage" (unpublished).

Exhibit 5-9

Percentage Distribution of Low and High Users Among Non-Institutionalized Aged Dual Enrollees and Other Aged Medicare Enrollees: 1980

	<u>Dual Enrollees</u>	<u>Medicare-Only/ No Private</u>	<u>Medicare-Only/ + Private</u>	<u>No Medicare</u>
HOSPITAL DISCHARGES				
• no discharges	.68	.83	.79	.88
• 1 discharge	.15	.13	.14	.10
• 2 or more discharges	.17	.05	.08	.02
	<u>1.00</u>	<u>1.00</u>	<u>1.00</u>	<u>1.00</u>
AMBULATORY VISITS				
• no visits	.07	.25	.12	.40
• 1-4 visits	.29	.34	.34	.23
• 5+ visits	.64	.41	.54	.37
	<u>1.00</u>	<u>1.00</u>	<u>1.00</u>	<u>1.00</u>
PHYSICIAN VISITS				
• no visits	.09	.28	.16	.40
• 1-4 visits	.33	.36	.37	.23
• 5+ visits	.58	.36	.48	.37
	<u>1.00</u>	<u>1.00</u>	<u>1.00</u>	<u>1.00</u>

Source: NMCUES (1980) data reported by Garfinkel, et al., op. cit.



As a result, aged dual enrollees paid a far smaller fraction of total health care costs out-of-pocket than other aged Medicare beneficiaries. On average, out-of-pocket expenditures for aged dual enrollees equalled only 7% of total costs incurred, compared to 20%-29% for other aged Medicare beneficiaries. Exhibit 5-10 presents mean total charges and mean out-of-pocket expenditures per aged dual enrollee and other aged individuals in 1980.

Since out-of-pocket expenditures played a disproportionately small role in the total health care costs of aged dual enrollees, who paid the rest of their health care charges? 1980 NMCUES data indicate that over half (57%) of aged dual enrollees' total charges were paid by Medicare. The remainder came primarily from Medicaid (37%). Exhibit 5-11 describes the distribution of mean annual per capita expenditures by source of payment for aged dual enrollees and aged Medicare-only enrollees.

Exhibit 5-11 also shows that aged dual enrollees relied far more heavily on public sources of payment than other aged Medicare beneficiaries. But the difference between dual enrollees and other aged Medicare beneficiaries was primarily due to Medicaid's contribution, not Medicare's. Medicare provided roughly comparable shares of expenditures for all groups of aged Medicare enrollees: 57% of expenditures for aged dual enrollees and 54%-67% of expenditures for other aged Medicare enrollees. In contrast, Medicaid provided 37% of expenditures for aged dual enrollees, but nothing to other aged Medicare enrollees; this latter group relied more heavily on private insurance and out-of-pocket expenditures.

### 5.2.3 Disabled Dual Enrollees: Characteristics

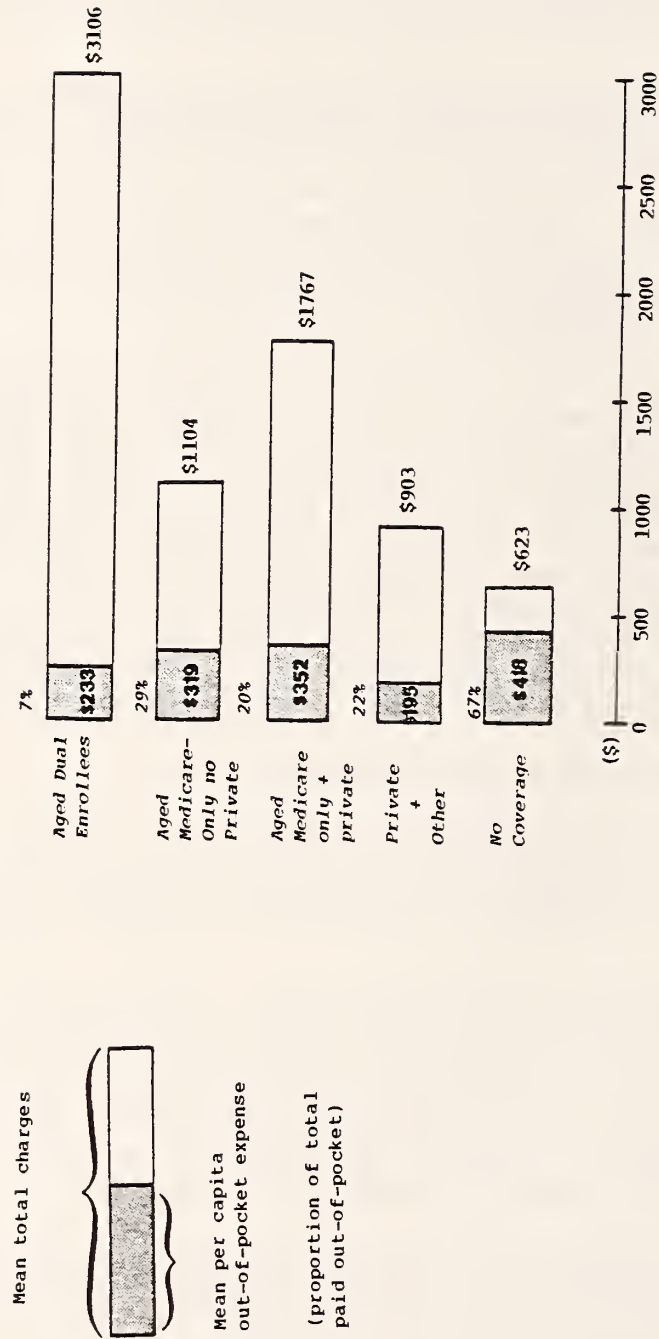
Disabled dual enrollees numbered 0.5 million in 1978, and formed roughly 21% of disabled Medicare Part B enrollment and 20% of disabled Medicaid recipients. Exhibit 5-12 illustrates the disabled dual enrollee share of Medicare and Medicaid enrollment in 1978.

The share of Medicare enrollment formed by disabled dual enrollees varied dramatically across States. State-by-State dual enrollment shares of disabled Medicare enrollment, presented in Exhibit 5-13, ranged from a low of 0.6% in Louisiana to a high of 47.2% in California. This variation was probably due, in part, to the restrictiveness of each State's Medicaid eligibility criteria and the restrictiveness of each State's buy-in agreement.

Compared to disabled Medicare-only enrollees, disabled dual enrollees were younger, with disproportionately more women and minorities. Exhibit 5-14 compares the age, sex, and race composition of disabled dual enrollees and disabled Medicare-only enrollees in 1978. Roughly 36% of disabled dual enrollees were

Exhibit 5-10

Mean Per Capita Annual Charges, Out-of-Pocket Expenses, and Proportion of Charges Paid Out-of-Pocket for Non-Institutionalized Aged Dual Enrollees and Other Non-Institutionalized Aged Groups: 1980



Source: NMCUES (1980) data reported by Howell, Embry; Corder, Larry; and Dobson, Allen, "Out-of-Pocket Health Expenses for Medicaid and Other Poor and Near Poor Persons in 1980," February 1983 (unpublished).

Exhibit 5-11

Total Health Care Expenditures from All Sources for Non-Institutionalized Aged Dual Enrollees and Other Non-Institutionalized Aged Medicare Enrollees: 1980

	Aged Dual Enrollees*	Aged Medicare-Only/ No Private**	Aged Medicare-Only/ + Private
• % of total Aged Medicare enrollment	10%	21%	67%
• % of total Aged health care charges (all sources)	18%	13%	68%
• mean per capita charges	\$3,133 ***	\$1,087	\$1,818
• % distribution of charges by source			
- out-of-pocket	4% ***	29%	20%
- Medicare	57%	67%	54%
- Medicaid	37%	0%	0%
- private	1%	0%	21%
- other	0%	1%	3%
- unknown	1%	1%	1%

\* Because of the construction of the tables in the report used for this table, this first column excludes aged dual enrollees who also had private insurance (i.e., those covered by Medicare, Medicaid, and private insurance). These dual enrollees --who form 19% of the non-institutionalized dual enrollee population -- are included in the third column: Aged Medicare-Only + Private.

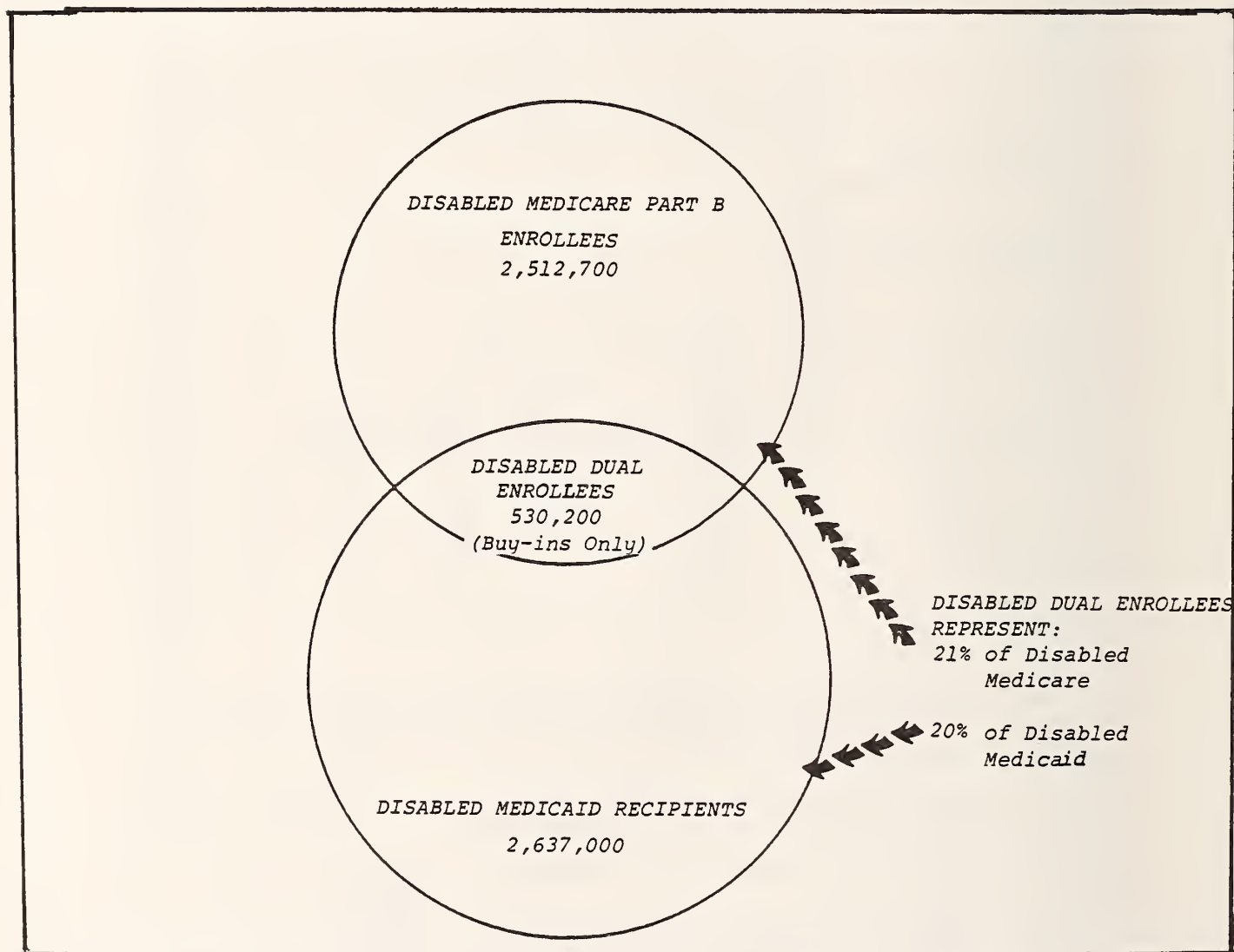
\*\* Excludes the 1% of Aged Medicaid enrollees who have no private coverage or Medicaid, but who do receive sizeable contributions from other sources.

\*\*\* Differs from the corresponding number in Exhibit 5-11 because it includes persons 64 and 65 years of age.

Source: NMCUES (1980) data reported by Garfinkel, et al., op. cit.

Exhibit 5-12

Disabled Dual Enrollees and Their Shares of Disabled Medicare  
and Medicaid Enrollment: 1978



Sources: Medicare and buy-in statistics from CMHS (1978) data in unpublished tables specified by Mcmillan and Pine. Medicaid statistic from HCFA 2082 (1978) data published in the Health Care Financing Review, op. cit.



## Exhibit 5-13

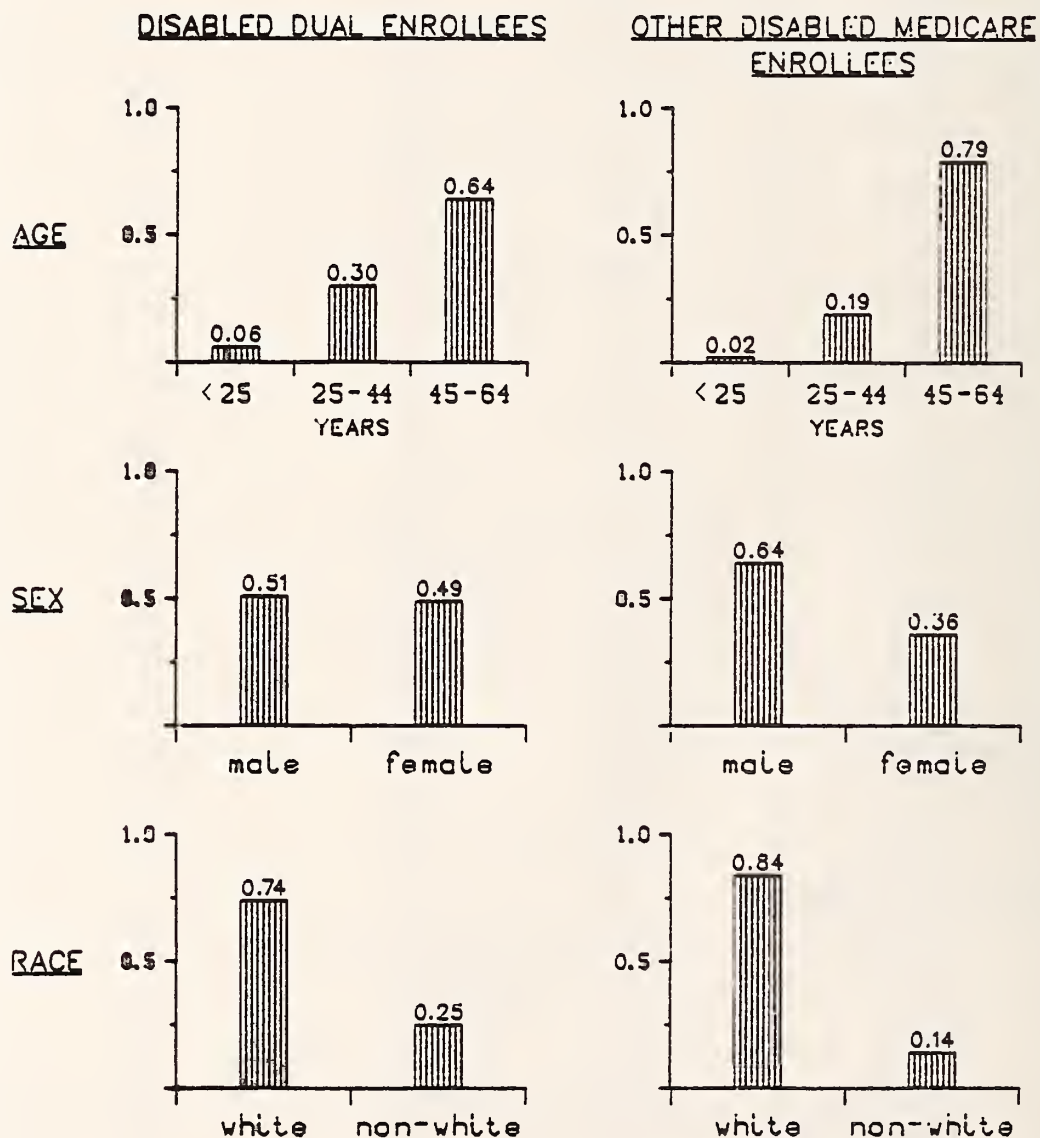
Disabled Dual Enrollees as a Percentage of Disabled Medicare Part B  
Enrollment, by State: 1978

STATE	Total Disabled Part B Enrollment	Total Disabled Dual Enrollees	Disabled Dual Enrollees As % of Disabled Part B
U.S. TOTAL	2,512,680	530,220	21.1%
Alabama	54,920	13,260	24.1%
Alaska	1,280	40	3.1%
Arizona	27,480	2,660	9.6%
Arkansas	40,920	10,060	24.5%
California	259,040	122,440	47.2%
Colorado	21,140	3,980	18.8%
Connecticut	26,820	2,180	8.1%
Delaware	5,760	980	17.0%
D.C.	7,660	2,860	37.3%
Florida	121,540	17,420	14.3%
Georgia	80,120	19,280	24.0%
Hawaii	6,580	2,660	40.4%
Idaho	8,680	1,700	19.5%
Illinois	99,680	5,760	5.7%
Indiana	55,840	6,720	12.0%
Iowa	26,500	5,220	19.7%
Kansas	19,140	4,900	25.6%
Kentucky	53,360	10,400	19.4%
Louisiana	52,680	320	0.6%
Maine	13,260	3,540	26.7%
Maryland	34,580	8,280	23.9%
Massachusetts	57,100	16,400	28.7%
Michigan	110,840	19,160	17.2%
Minnesota	32,640	3,480	10.6%
Mississippi	40,040	8,720	21.7%
Missouri	59,860	9,340	15.6%
Montana	8,460	1,960	23.1%
Nebraska	11,920	1,960	16.4%
Nevada	6,860	620	9.0%
New Hampshire	8,320	640	7.6%
New Jersey	79,540	13,980	17.5%
New Mexico	13,360	2,800	20.9%
New York	199,680	43,640	21.8%
North Carolina	79,060	14,400	18.2%
North Dakota	4,980	660	13.2%
Ohio	122,640	22,920	18.6%
Oklahoma	34,500	4,140	12.0%
Oregon	25,340	420	1.6%
Pennsylvania	144,700	22,020	15.2%
Rhode Island	11,100	2,240	20.1%
South Carolina	45,240	10,640	23.5%
South Dakota	6,600	1,320	20.0%
Tennessee	66,880	13,100	19.5%
Texas	122,800	27,600	22.4%
Utah	8,540	1,560	18.2%
Vermont	5,680	1,500	26.4%
Virginia	57,640	13,240	22.9%
Washington	38,980	10,320	26.4%
West Virginia	40,620	4,940	12.1%
Wisconsin	45,500	11,300	24.8%
Wyoming	2,540	40	1.5%

Source: CMHS (1978) data in unpublished tables specified by Mcmillan and Pine.

Exhibit 5-14

Age, Sex, and Race Composition of Disabled Dual Enrollees and Other Disabled Medicare Enrollees: 1978



Source: CMHS (1978) data in unpublished tables specified by Mcmillan and Pine.

under 45, compared to 21% of disabled Medicare-only enrollees. In addition, 49% of disabled dual enrollees were female, compared to 36% of disabled Medicare-only enrollees. And 25% of disabled dual enrollees were non-white, compared to 14% of disabled Medicare-only enrollees.

The disproportionate presence of women and minorities among disabled dual enrollees seems consistent with demographic differences between the poor and non-poor: one would expect dual enrollees (who qualify for Medicaid) to have more women and minorities than their counterparts who have only Medicare coverage.

The relative youth of disabled dual enrollees compared to other disabled Medicare enrollees may be explained, in part, by the fact that disabled persons over 45 probably have more resources than disabled persons under 45, and thus, are less likely to qualify for Medicaid. For example, disabled persons over 45 have probably been in the workforce longer than their younger counterparts, and thus have probably accumulated more assets, higher Social Security benefits, and higher private pension benefits. They may also have older children who can contribute to their health care and other living expenses. It is therefore not surprising to find that disabled dual enrollees were younger than the rest of the disabled Medicare population.

There was very little information comparing the health status of disabled dual enrollees to disabled Medicare-only beneficiaries. CMHS data on death rates, however, indicated that disproportionately fewer disabled dual enrollees died during 1978 than disabled Medicare-only beneficiaries. Exhibit 5-15 indicates that even after adjusting the death rates to control for the relative youth of disabled dual enrollees, death rates for disabled dual enrollees were 14% lower than those for other disabled Medicare enrollees.

In theory, disabled dual enrollees can also be compared to a sizeable disabled Medicaid-only population. Unfortunately, national data comparing disabled dual enrollees and other disabled Medicaid recipients were not yet available.<sup>38</sup> At present, limited Medicaid enrollment data for only the State of New York permit a comparison between disabled dual enrollees and the total disabled Medicaid population. Though New York is hardly representative of the national Medicaid population, it does provide detailed Medicaid enrollment data on these two populations.

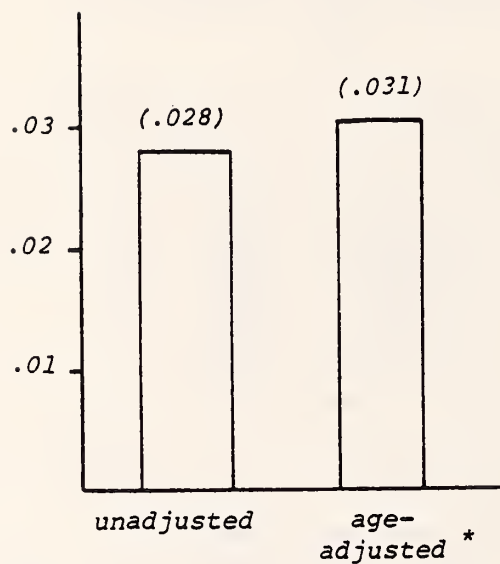
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<sup>38</sup>1980 NMCUES data can eventually support such a comparison, but existing tabulations do not distinguish disabled dual enrollees from disabled Medicaid-only enrollees.

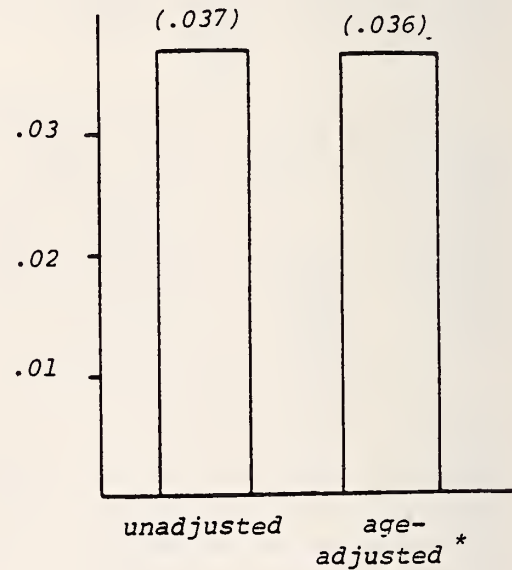
Exhibit 5-15

Death Rates for Disabled Dual Enrollees  
and Other Disabled Medicare Enrollees: 1978

DISABLED DUAL  
ENROLLEES  
(proportion dying)



OTHER DISABLED  
MEDICARE  
ENROLLEES  
(proportion dying)



\* Adjusted to correspond to the age profile of the total disabled Medicare population.

Source: CMHS (1978) data in unpublished tables specified by  
McMillan and Pine.



In New York in 1981, disabled dual enrollees had proportions of men and women which were very close to those of the total disabled Medicaid population. 1981 Tape-to-Tape data in Exhibit 5-16 reveal that close to 60% of both disabled dual enrollees and all disabled Medicaid enrollees were women. But disabled dual enrollees differed from the total disabled Medicaid population in New York in two important respects. First, disabled dual enrollees had disproportionately more persons over 65 (32%) than the total disabled Medicaid population (12%).<sup>39</sup> Second, disabled dual enrollees had disproportionately more medically needy enrollees (21%) than the total disabled population (13%). Exhibit 5-16 presents sex, age and eligibility status data for these two disabled groups in New York.

The older age composition of disabled dual enrollees relative to all disabled Medicaid enrollees in New York may be partially explained by differences in Medicare and Medicaid eligibility requirements. In particular, Medicare's Social Security insurance requirements tend to exclude younger disabled Medicaid enrollees. For example, Medicare does not generally cover disabled children; it covers only the small fraction of disabled children who are children of Social Security recipients or who suffer from chronic renal disease. In contrast, Medicaid covers all children who satisfy SSI's disability requirements. Medicare is also not granted until a disabled applicant has qualified for or received Social Security disability benefits for at least two years. As a result, disabled Medicaid enrollees who do not qualify for Medicare are likely to be younger than disabled dual enrollees (who do qualify for Medicare).

It is also not surprising to see that the medically needy are disproportionately represented among dual enrollees. Disabled dual enrollees probably have more income and assets than their Medicaid-only counterparts; they have, for example, Social Security benefits to draw upon. In contrast, disabled Medicaid-only enrollees have not amassed sufficient quarters of Social Security coverage to qualify for Social Security benefits. They are therefore likely to have fewer resources than dual enrollees, and thus more likely to qualify as categorically needy.

#### 5.2.4 Disabled Dual Enrollees: Utilization and Expenditures

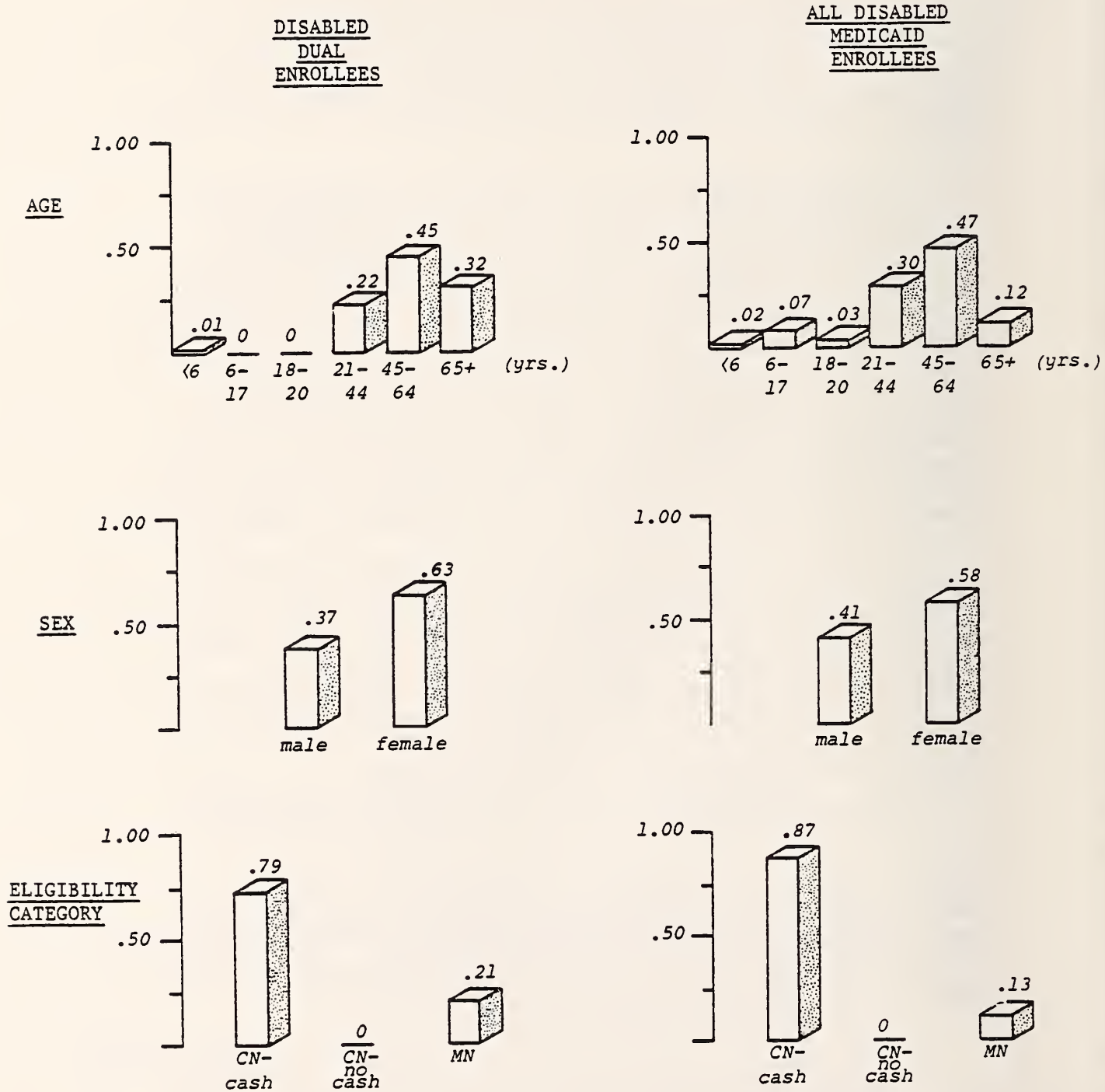
It is, unfortunately, impossible to tell from existing data whether disabled dual enrollees were generally high, medium, or low users of health care. Disabled dual enrollees did have higher per capita Medicare utilization rates and expenditures than disabled Medicare-only enrollees, but existing data did not permit a national comparison of Medicaid utilization and expenditures.

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<sup>39</sup>Unlike Medicare, some State Medicaid programs, such as New York's, do not automatically convert "disabled" enrollees to "aged" enrollees when they turn age 65.

Exhibit 5-16

Age, Sex, and Eligibility Distributions of Disabled Dual Enrollees  
and All Disabled Medicaid Enrollees in New York: 1981



Source: New York Tape-to-Tape enrollment data (1981) in Early Returns Tables.

With respect to Medicare-covered services, disabled dual enrollees had Medicare reimbursements per enrollee of \$775 for Part A services and \$544 for Part B services -- roughly 20% and 30% higher than corresponding reimbursements for disabled Medicare-only beneficiaries. Part of this difference was due to higher utilization rates among disabled dual enrollees; part was due to higher reimbursements per recipient. For example, Exhibit 5-17 indicates that the proportion of disabled dual enrollees who were recipients of Medicare services was 10%-20% higher than the proportion of disabled Medicare-only enrollees who were recipients.

Disabled dual enrollees also had disproportionately more users of each major Medicare service than disabled Medicare-only enrollees: their user rates were 10%-100% higher. In addition, disabled dual enrollees had Medicare hospital discharge rates which were, on average, 10%-20% higher than those of disabled Medicare-only enrollees.

Currently available data provide few clues as to why disabled dual enrollees had higher Medicare utilization rates and expenditures than disabled Medicare-only enrollees. Age was not, for example, a factor: after the data were adjusted to control for the relative youth of disabled dual enrollees, the differences between dual enrollees and other disabled Medicare enrollees increased. Mortality rates also provided no clue, since disabled dual enrollees had lower age-specific death rates than other disabled Medicare enrollees.

### 5.3 State Buy-in Decisions

Although dual enrollees are, by definition, enrolled in both Medicare and Medicaid, not all dual enrollees have complete Medicare coverage. Medicare, in fact, consists of two separate but related programs: Medicare Hospital Insurance (Part A) and Medicare Supplementary Insurance (Part B). Aged persons (65 and over) who qualify for (or receive) Social Security or Railroad Retirement benefits can enroll in Part A and Part B, though a monthly premium payment is required for Part B. Aged persons who do not qualify for these retirement benefits can still enroll in Parts A and B, but they have to pay a special monthly premium for Part A coverage. Most aged Medicaid enrollees have at least Medicare Part A coverage, and are therefore dual enrollees.

Disabled persons (under age 65) can enroll in Parts A and B only if they qualify for (or receive) Social Security disability benefits for at least two years. There is no provision for the disabled who do not qualify for such benefits. Far fewer disabled (than aged) Medicaid enrollees qualify for Medicare.

Exhibit 5-17

Medicare Reimbursements and Utilization Rates for Disabled Dual Enrollees and Other Disabled  
Medicare Enrollees: 1978

	Disabled Dual Enrollees		Other		RATIO:	
	Unadjusted	Age-Adjusted	Disabled Medicare Enrollees	Age-Adjusted	Dual Enrollees to Other Enrollees	Age-Adjusted
• reimbursements/enrollee						
- Part A	\$775	\$809	\$656	\$652	1.2	1.2
- Part B	\$544	\$538	\$403	\$406	1.3	1.3
• reimbursements/recipient						
- Part A	\$3156	\$3152	\$2811	\$2830	1.1	1.1
- Part B	\$857	\$837	\$754	\$789	1.1	1.1
• recipients/1000 enrollees						
- Part A	246	257	233	231	1.1	1.1
- Part B	635	662	534	529	1.2	1.3
• recipients/1000 enrollees (by services)						
- Part A: Inpatient Hospital	248	NA	235	NA	1.1	NA
- Part A: SNF	4	NA	2	NA	2.0	NA
- Part A: Home Health	17	NA	14	NA	1.2	NA
- Part B: Physician	586	NA	494	NA	1.2	NA
- Part B: Other Medical	191	NA	123	NA	1.6	NA
- Part B: Outpatient	356	NA	260	NA	1.4	NA
- Part B: Home Health	10	NA	7	NA	1.4	NA
• hospital discharges/ 1000 enrollees	426	447	380	377	1.1	1.2

Source: CMHS (1978) data in unpublished tables specified by McMillan and Pine.



The subset of aged and disabled dual enrollees who have Part B coverage obtain it through one of two routes: either they pay the Part B premium themselves or State Medicaid programs pay the premium for them. This latter group of people form the subset of dual enrollees who are "buy-ins" -- individuals for whom State Medicaid programs pay the monthly Part B premiums.

States elect to "buy-in" Medicare Part B coverage for some or all of their dual eligibles in order to shift some of their physician, outpatient, home health and other medical expenses to Medicare. In "buying-in" for dual eligibles, Medicaid programs pay the monthly premiums and the coinsurance and deductibles for Part B services. In return, Medicare becomes the first payor for all services now covered by Medicare Part B.

Given such an arrangement, one might expect States to "buy-in" for all their dual eligibles on Medicaid. But, in fact, they do not. Currently, only 27 States purchase Medicare coverage for all their eligible Medicaid enrollees; 21 purchase coverage for only cash assistance recipients, and the remaining 3 have no buy-in arrangement at all. Exhibit 5-18 describes the various State buy-in agreements as of 1983.

These interstate differences in buy-in arrangements may be due, in part, to different financial incentives facing State Medicaid programs. They may also be due to a variety of other factors, including the administrative complexity of buy-in arrangements. This section examines only the financial incentives facing State Medicaid programs, and the extent to which variations in State buy-in arrangements appear justified by variations in financial incentives. The data in this section unfortunately date back to 1978; more recent data were not available.

#### 5.3.1 Incentives Surrounding States' Buy-in Decisions

The Federal government and the States share the cost of health care for dual enrollees in a complicated fashion. States can alter this share in only limited ways.

For all dual enrollees, regardless of buy-in status, Medicare is the first payor for all services covered by Medicare. This, of course, depends on whether the dual enrollee has Part A coverage, Part B coverage, or both. In return, Medicaid programs are obligated to cover the Medicare deductibles and coinsurance for dual enrollees. But the range of Medicare Part B services for which Medicaid programs must pay deductibles and coinsurance depends on whether the dual enrollee is a "buy-in."

State Buy-in Agreements: 1983

States Which Buy-in For Only Cash Assistance Recipients:

Connecticut	New York
Delaware	North Dakota
Illinois	Oklahoma
Kentucky	Pennsylvania
Maine	Rhode Island
Massachusetts	South Dakota
Michigan	Tennessee
Minnesota	Vermont
Missouri	West Virginia
Nebraska	Wisconsin
New Hampshire	

States Which Buy-in For Cash and Non-Cash Recipients, but Which Lack a Medically Needy Program:

Alabama	Mississippi
Colorado	Nevada
Florida	New Jersey
Georgia	New Mexico
Idaho	Ohio
Indiana	South Carolina
Iowa	Texas

States Which Buy-in for Cash and Non-Cash Recipients, including the Medically Needy:

Alaska*	Maryland
Arizona**	Montana
Arkansas	North Carolina
California	Utah
District of Columbia	Virginia
Hawaii	Washington
Kansas	

States with No Buy-in Agreements

Louisiana  
Oregon  
Wyoming

\* Recently initiated. Became effective October 1982. Previously, Alaska had no buy-in agreement.

\*\* Recently initiated following introduction of Medicaid in the state. Became effective 1982. Previously, Arizona bought-in for only certain SSI recipients.

For dual enrollees who are not buy-ins, Medicaid is obligated to pay the coinsurance and deductibles for only those Medicare services included in the State's Medicaid plan. In contrast, for buy-ins, Medicaid is obligated to pay the coinsurance and deductibles for all Part B services, even if some of these services are not included in the State plan.<sup>49</sup>

States can also affect their program costs by buying-in only certain groups of dual eligibles on Medicaid. Current Federal regulations allow States to distinguish between cash and non-cash Medicaid enrollees in their buy-in agreements with Medicare. They also create different financial incentives for buying-in these two groups.

When a State buys-in Part B coverage for its cash assistance recipients, it pays the monthly Part B premium, the Part B deductible, and the 20% coinsurance on all Part B services (except home health).<sup>41</sup> But the State can shift some of these "buy-in costs" back to the Federal government, through Medicaid's Federal Financial Participation (FFP or matching) payments. In other words, the Federal government reimburses the State Medicaid program for its FFP share of the premium, deductible and coinsurance costs associated with buying-in cash assistance Medicaid enrollees.

The story is slightly different, however, for non-cash Medicaid enrollees (i.e., the categorically needy/no cash and medically needy populations). For non-cash buy-ins, the State Medicaid program pays the Part B premium, deductible, and coinsurance. But the Federal government now reimburses it for only the deductible and coinsurance costs associated with non-cash buy-ins; it will not provide FFP reimbursement for the premium payments associated with non-cash buy-ins.

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<sup>40</sup>Regulations have recently been proposed to make cost-sharing on some Medicare services optional for State Medicaid programs. Such rules would permit States to opt out of cost-sharing for those Part B services not included in the State Medicaid plan.

<sup>41</sup>Because Medicaid is obligated to pay the deductibles and coinsurance for Part A services for all dual enrollees -- regardless of their buy-in status -- these Part A-related costs are not treated as part of the buy-in decision. Hence, most of the discussion in this section refers to only Part B services.



Thus, at first glance, States appear to pay more to buy-in cash assistance Medicaid enrollees than non-cash assistance enrollees. Yet there is an additional twist to the financial incentives surrounding buy-in decisions: if a State elects not to buy-in for any Medicaid enrollees who qualifies for Medicare, it cannot receive Federal (FFP) reimbursement for the Medicaid services used by that enrollee. More precisely, Federal statute prohibits the Federal government from providing FFP for Medicaid services that could have been covered by Medicare. As a result, a State could possibly lose money if it does not buy-in an eligible Medicaid enrollee, and that enrollee subsequently uses a number of Medicaid services.

The regulations surrounding State buy-in agreements are complex, but a simple model may summarize the financial incentives surrounding buy-in policies. Let

- $P_i$  = total premium costs associated with buying-in a given group of Medicaid buy-ins,  $i$ , in a single State
- $C_i$  = total Medicaid (State plus Federal) program costs for deductibles and coinsurance for buy-in group  $i$  in a single State
- $R_i$  = total Medicare reimbursements for Part B services for buy-in group  $i$  in a single State
- $S$  = the State's share of Medicaid service costs under FFP arrangements  
( $1 - \text{FFP} = S$ )
- $i$  = 1 for cash assistance buy-ins
- $i$  = 2 for non-cash assistance buy-ins

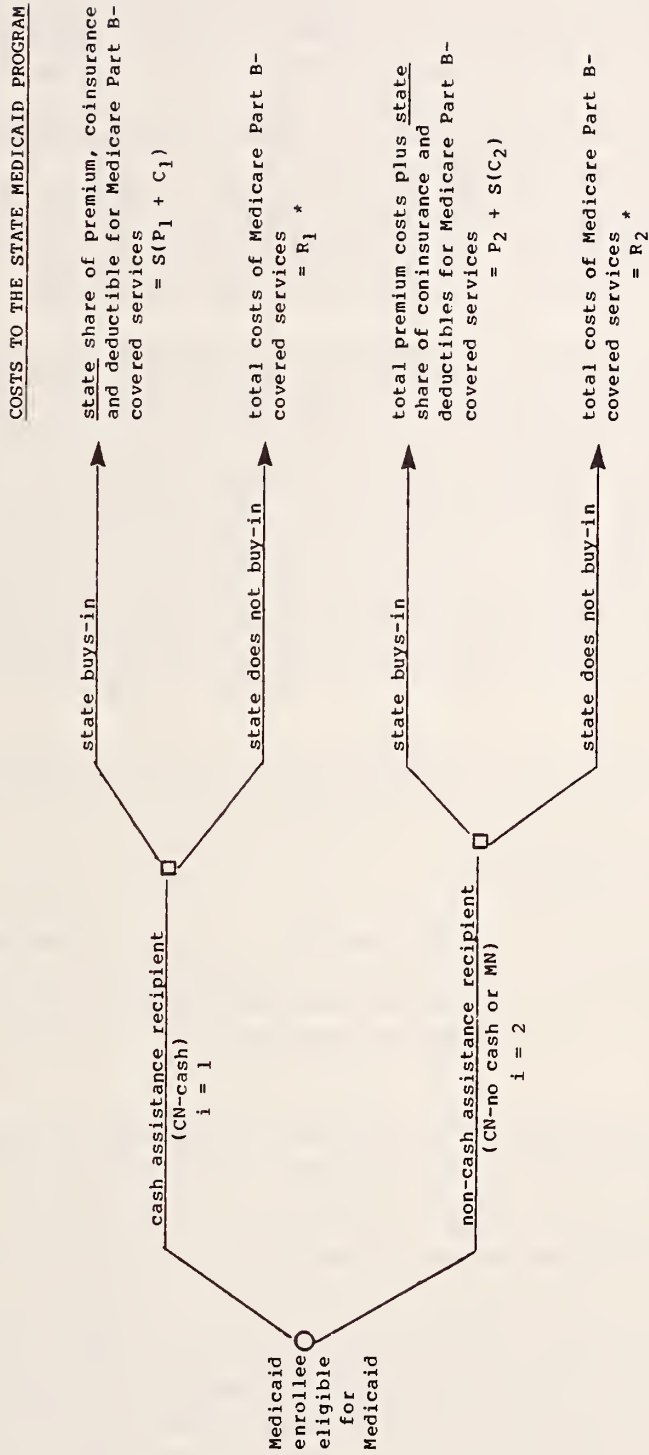
Exhibit 5-19 summarizes the State's buy-in decision, incorporating the model's variables. If a State buys-in for cash assistance recipients, it must pay  $S(P_1 + C_1)$ . If, however, it does not buy-in for cash assistance recipients, it pays  $R_1$ . Similarly, if a State buy-ins for non-cash assistance recipients, it must pay  $P_2 + S(C_2)$ ; if it does not buy-in for non-cash assistance recipients, it pays  $R_2$ .

One can use  $R_1$  and  $R_2$  to describe the full cost of Medicaid services that could have been covered by Medicare, if one assumes that (a) Medicare reimbursements exactly match Medicaid reimbursements for comparable services, (b) the same services would have been covered by both Medicare and Medicaid, and (c) States and the Federal government are able to identify those persons who could be enrolled in Medicare Part B but are not. Though one may argue with these assumptions, they are reasonable for the purposes of this analysis.



# Exhibit 5-19

The State Buy-in Decision (as described by the model)



\* This diagram omits the probably small costs states could avoid by not having to pay the coinsurance or deductibles associated with Medicare Part B services not covered in the state Medicaid plan.

In addition, this model excludes a source of potential savings to States who do not buy-in for all their dual eligibles: savings due to the fact that they need not pay the coinsurance and deductibles for those Part B services not included in State plans. These savings were excluded from the model (and the discussion) because they were (a) presumed to be small, and (b) impossible to measure with existing data and resources.

### 5.3.2 Computing the Savings from State Buy-in Decisions

Although Congress intended to encourage all States to buy-in for all dual eligibles on Medicaid, not all the States have found the incentives compelling. As noted previously, only 27 States purchased Medicare coverage for all their dual eligibles.

In order to better understand why the remaining 24 States do not buy-in for all their dual eligibles, the "costs" and "returns" associated with buy-in decisions were analyzed, to determine whether buy-in decisions generated, on net, savings or losses to various States. The costs of buying-in were defined as the State's share of Medicaid payments for Medicare premiums, deductibles, and coinsurance for buy-ins. The returns associated with buying-in were defined as those Medicare Part B reimbursements for services that State Medicaid programs would have had to cover if they had not enrolled their dual eligibles in Medicare. Net savings due to buying-in were, in turn, defined as the excess of returns over costs. In other words,

$$\begin{array}{rclclcl} \text{returns} & & & \text{costs of} & & \text{net savings} \\ \text{from} & - & & \text{buying-in} & = & \text{due to buying-in} \\ \text{buying-in} & & & & & \end{array}$$

(or in terms of the model)

$$\begin{array}{rclclcl} R_i & - & S(P_i + C_i) & = & \text{net savings} \\ \text{(Medicare Part B} & & \text{(State share of Medicaid} & & \\ \text{reimbursements)} & & \text{payments for Medicare} & & \\ & & \text{premiums, deductibles,} & & \\ & & \text{and coinsurance)} & & \end{array}$$

If net savings were positive, the State saved money by buying-in. If net savings were negative, the State lost money by buying-in.<sup>42</sup>

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<sup>42</sup>Note that this term should differ for cash and non-cash buy-ins. For cash, the term should be  $S(P_i + C_i)$ , and for non-cash it should be  $P_i + SC_i$ . But existing data bases did not permit costs for cash and non-cash buy-ins to be disaggregated. As a result, all Medicaid buy-in costs were treated like buy-in costs for cash assistance enrollees, and it was assumed that all premium expenditures were eligible for FFP. This had the effect of understating the costs, somewhat, since premium expenditures for non-cash enrollees were not eligible for FFP.

Measuring these "net savings" proved to be difficult, given existing data bases. The ideal data set would have included matched person-level data on both Medicare and Medicaid expenditures for buy-ins. (It would also have included detailed data on administrative costs associated with different buy-in policies.) The actual data available, however, were far from ideal. National data on Medicaid and Medicare service expenditures for buy-ins were neither matched nor complete. Costs had to be derived from aggregate and person-level data from different sources. In addition, data on both Medicare and Medicaid expenditures were only as current as 1978 -- the most recent year for which both Medicare and Medicaid buy-in data were available. Finally, data describing the administrative costs associated with different buy-in policies were simply not available. Consequently, the numbers which follow should be viewed with these limitations in mind.

Costs Associated with Buy-In Policies [ $S(P_i + C_i)$ ]. HCFA 120 and 2082 aggregate data were the best sources of information on Medicaid premium, deductible, and coinsurance costs for Part B services. HCFA 120 data, for example, described Medicaid "premium" payments to Medicare on behalf of aged and disabled enrollees for FY 1978. Though these data were not person-based, they corresponded exactly to the buy-in population, since buy-ins were the only Medicaid group for whom States made premium payments. HCFA 2082 data supplemented the 120 data by providing data on Part B deductible and coinsurance payments made to Medicare on behalf of aged and disabled dual enrollees for 1978.

There were, however, three problems with these HCFA data. First, the 2082 data overstated costs to the extent they included deductible and coinsurance payments for dual enrollees who purchased their own Part B coverage. Second, several States did not submit complete HCFA 120 and 2082 reports: only 33 States had complete cost data for aged buy-ins and only 24 States had complete cost data for disabled buy-ins. Third, premium expenditures for cash assistance recipients (eligible for FFP) could not be distinguished from premium expenditures for non-cash recipients (not eligible for FFP). As a result, FFP ratios were applied to all premium costs, thereby understating actual State premium costs to some extent.

Average<sup>43</sup> State costs associated with positive buy-in decisions were higher for disabled buy-ins than for aged buy-ins: \$110 per disabled buy-in and \$73 per aged buy-in. Cost data presented in Exhibit 5-20 indicate that these per capita costs varied dramatically across States. For aged buy-ins, per capita

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<sup>43</sup>All averages in this section refer to the "mean State," where the denominator is the total number of States rather than the total number of buy-ins.

## Exhibit 5-20

State Costs<sup>1</sup> Associated with Buying-in, By State: 1978  
 (includes Medicare premiums, coinsurance, and deductibles)

	AGED	DISABLED
All states' mean	\$73	\$110
States Which Bought-in for Only Cash Assistance Recipients*		
Connecticut	\$158	\$ <sup>3</sup>
Delaware	\$83	\$69
Kentucky	\$47	\$ <sup>3</sup>
Michigan	\$66	\$89
Minnesota	\$140	\$241
Missouri	\$123	\$119
Nebraska	\$112	\$155
New Hampshire	\$118	\$140
North Dakota	\$7 <sup>2</sup>	\$109
Oklahoma	\$58	\$61
Pennsylvania	\$34	\$67
Tennessee	\$53	\$ <sup>3</sup>
Vermont	\$71	\$ <sup>3</sup>
W. Virginia	\$34	\$ <sup>3</sup>
States Which Bought-in for Cash and Non-Cash Recipients, But Which Lacked a Medically Needy Program**		
Georgia	\$56	\$ <sup>3</sup>
Idaho	\$43	\$48
Indiana	\$61	\$135
Iowa	\$74	\$65
Mississippi	\$44	\$35
Nevada	\$102	\$170
New Jersey	\$63	\$76
Ohio	\$84	\$42
Texas	\$70	\$86
States Which Bought-in for Cash and Non-Cash Recipients including the Medically Needy***		
Arkansas	\$45	\$ <sup>3</sup>
California	\$114	\$478
District of Columbia	\$76	\$74
Hawaii	\$86	\$ <sup>3</sup>
Maryland	\$91	\$ <sup>3</sup>
Montana	\$69	\$53
North Carolina	\$51	\$76
Virginia	\$60	\$115
Washington	\$47	\$41

1 Cost data did not distinguish between cash and non-cash recipients. Thus, all premium costs were reduced to the state's FFP share, and may therefore understate the premium costs associated with non-cash recipients.

2 Looked unbelievably low; equivalent to less than one month's premium payment. There were probably some serious problems with this state's data, but this figure is included here because it was derived from ostensibly complete records.

3 Complete data were not available.

\* Excludes the following states for which complete buy-in cost data were not available: Illinois, Maine, Massachusetts, New York, Rhode Island, and South Dakota.

\*\* Excludes the following states for which complete buy-in cost data were not available: Alabama, Colorado, Florida, New Mexico and South Carolina.

\*\*\* Excludes the following states for which complete buy-in cost data were not available: Kansas, Utah.

Source: HCFA 120 and 2082 (1976) data from unpublished tables provided by HCFA.



costs associated with positive buy-in decisions ranged from \$7 per aged buy-in in North Dakota to \$158 per aged buy-in in Connecticut. For disabled buy-ins, they ranged from \$35 per disabled buy-in in Mississippi to \$470 per disabled buy-in in California.

Returns Associated with Buy-in Decisions [ $R_i$ ]. The data used in this section described actual Medicare Part B reimbursements made on behalf of buy-ins. These data were used to approximate what Medicaid expenditures would have been if these people had not been covered by Medicare.

Average State Medicare Part B reimbursements were higher for disabled buy-ins than for aged buy-ins: \$477 per disabled buy-in and \$320 per aged buy-ins. Like Medicaid buy-in costs, Medicare reimbursements varied dramatically across States: reimbursements per aged buy-in ranged from \$185 in West Virginia to \$592 in California. Reimbursements per disabled buy-in ranged from \$171 in Montana to \$1,045 in the District of Columbia. State by State reimbursement data are presented in Exhibit 5-21.

Net Savings Associated with Buy-in Decisions, [ $R_i - S(P_i + C_i)$ ]. Exhibit 5-22 summarizes available data on the net savings generated by each State's buy-in policy. For every State for which reasonably complete cost data were available, buying-in generated positive savings. Average savings for aged buy-ins ranged from \$138 per aged buy-in in Missouri to \$470 per aged buy-in in California. For disabled buy-ins, average savings ranged from \$118 per disabled buy-in in Montana to \$971 per disabled buy-in in D.C.

Average savings were also generally higher for disabled buy-ins than for aged buy-ins, due to the higher per capita Medicare expenditures incurred by disabled buy-ins. The average State saved \$367 per disabled buy-in and \$246 per aged buy-in.

In an attempt to explain the interstate variation in net savings from buy-in decisions, average savings were compared for three groups of States, divided according to the restrictiveness of their buy-in agreements and Medicaid programs:

- States covering only cash assistance recipients
- States covering cash and non-cash assistance recipients, but lacking a medically need program
- States covering cash and non-cash assistance recipients, including the medically needy

Average savings appeared to vary directly with the comprehensiveness of buy-in arrangements. In other words, States which included the medically needy in buy-in agreements had the highest average savings: \$327 per aged buy-in and \$465 per disabled

## Exhibit 5-21

Medicare Part B Reimbursements per Buy-in, By State: 1978

	AGED	DISABLED
All states' mean	\$320	\$477
States Which Bought-in for Only Cash Assistance Recipients*		
Connecticut	\$449	\$ <u>    </u> <sup>1</sup>
Delaware	\$268	\$847
Kentucky	\$187	\$ <u>    </u> <sup>1</sup>
Michigan	\$361	\$503
Minnesota	\$292	\$581
Missouri	\$261	\$261
Nebraska	\$272	\$302
New Hampshire	\$289	\$476
North Dakota	\$249	\$295
Oklahoma	\$247	\$267
Pennsylvania	\$332	\$529
Tennessee	\$204	\$ <u>    </u> <sup>1</sup>
Vermont	\$277	\$ <u>    </u> <sup>1</sup>
W. Virginia	\$185	\$ <u>    </u> <sup>1</sup>
States Which Bought-in for Cash and Non-Cash Recipients, But Which Lacked a Medically Needy Program**		
Georgia	\$250	\$ <u>    </u> <sup>1</sup>
Idaho	\$225	\$228
Indiana	\$287	\$466
Iowa	\$253	\$287
Mississippi	\$246	\$640
Nevada	\$386	\$308
New Jersey	\$506	\$599
Ohio	\$329	\$357
Texas	\$332	\$616
States Which Bought-in for Cash and Non-Cash Recipients including the Medically Needy***		
Arkansas	\$239	\$ <u>    </u> <sup>1</sup>
California	\$592	\$780
District of Columbia	\$576	\$1,045
Hawaii	\$543	\$ <u>    </u> <sup>1</sup>
Maryland	\$430	\$ <u>    </u> <sup>1</sup>
Montana	\$322	\$171
North Carolina	\$280	\$602
Virginia	\$307	\$565
Washington	\$350	\$465

1 Data are not recorded for those states for which corresponding buy-in cost data were incomplete.

\* Excludes the following states for which complete buy-in cost data were not available: Illinois, Maine, Massachusetts, New York, Rhode Island, and South Dakota.

\*\* Excludes the following states for which complete buy-in cost data were not available: Alabama, Colorado, Florida, New Mexico and South Carolina.

\*\*\* Excludes the following states for which complete cost data were not available: Kansas, Utah.

Source: CMHS (1978) data published by McMillan, et al., Health Care Financing Review, op. cit., and from unpublished tables specified by McMillan and Pine:

Exhibit 5-22

Net Per Capita Savings Associated with Buying-in, By State: 1978  
(Savings Equal Medicare Part B Reimbursements to States  
Minus Buy-in Costs)

	AGED	DISABLED
All states' mean	\$246	\$367
States Which Bought-in for Only Cash Assistance Recipients*		
Connecticut	\$291	\$ 1
Delaware	\$185	\$778
Kentucky	\$140	\$ 1
Michigan	\$295	\$414
Minnesota	\$152	\$340
Missouri	\$138	\$142
Nebraska	\$160	\$147
New Hampshire	\$171	\$336
North Dakota	\$242	\$186
Oklahoma	\$189	\$206
Pennsylvania	\$298	\$462
Tennessee	\$151	\$ 1
Vermont	\$206	\$ 1
W. Virginia	\$151	\$ 1
States Which Bought-in for Cash and Non-Cash Recipients, But Which Lacked a Medically Needy Program**		
Georgia	\$194	\$ 1
Idaho	\$182	\$180
Indiana	\$226	\$331
Iowa	\$179	\$222
Mississippi	\$202	\$605
Nevada	\$284	\$138
New Jersey	\$443	\$523
Ohio	\$245	\$315
Texas	\$262	\$530
States Which Bought-in for Cash and Non-Cash Recipients including the Medically Needy***		
Arkansas	\$194	\$ 1
California	\$478	\$302
District of Columbia	\$440	\$971
Hawaii	\$457	\$ 1
Maryland	\$339	\$ 1
Montana	\$253	\$118
North Carolina	\$229	\$526
Virginia	\$247	\$450
Washington	\$303	\$424

1 Savings could not be computed for those states for which corresponding buy-in cost data were incomplete.

\* Excludes the following states for which complete buy-in cost data were not available: Illinois, Maine, Massachusetts, New York, Rhode Island, and South Dakota.

\*\* Excludes the following states for which complete buy-in cost data were not available: Alabama, Colorado, Florida, New Mexico and South Carolina.

\*\*\* Excludes the following states for which complete cost data were not available: Kansas, Utah.

Sources: HCFA 120 and 2082 (1978) data from unpublished tables provided by HCFA. Also CMHS (1978) data published by McMillan, et al., Health Care Financing Review, op. cit., and from unpublished tables specified by Mcmillan and Pine.

buy-in. In contrast, States which included only cash assistance recipients experienced the lowest average savings: \$198 per aged buy-in and \$318 per disabled buy-in. Data describing the variation in savings across buy-in agreements are summarized in Exhibit 5-23.

This pattern in savings was driven, in large part, by patterns in Medicare reimbursements across States. More specifically, States with the most comprehensive buy-in agreements also had the highest average reimbursements (\$398 per aged buy-in and \$605 per disabled buy-in). Similarly, States with the least comprehensive buy-in agreements (including only cash assistance recipients) had the lowest average reimbursements (\$277 per aged buy-in and \$433 per disabled buy-ins).

In sum, buying-in appeared to be a "good deal" for all States which bought-in: net savings per capita were positive for every State identified in the data. Moreover, net savings per capita were, on average, greatest for those States with the most comprehensive buy-in agreements (covering the medically needy).

#### Limitations of the Analysis

The quality of existing data severely limited the sophistication of the buy-in analysis. Currently available data described Medicare reimbursements only for Medicaid enrollees who were already buy-ins; they could not identify what Medicaid would have had to pay if these people had not been bought-in. As a result, the analysis reveals only that those States which did buy-in for non-cash Medicaid enrollees realized higher net savings than those which did not buy-in for non-cash Medicaid enrollees. It is therefore possible that those States which did not buy-in for all dual eligibles had good reasons for restricting their buy-in agreements -- reasons which could not surface in this simple numeric analysis of buy-ins.

For example, some States may currently refrain from buying-in all dual eligibles because they believe most dual eligibles are able and likely to pay their own Medicare Part B premiums. This may be especially true for dual eligibles who qualify for Medicaid as medically needy; they are likely to have (and to use) their own assets to cover their health care expenses -- e.g., personal income or supplemental private insurance -- before they qualify for Medicaid. In such cases, these individuals may already be on Medicare when they qualify for Medicaid, and thus may be paying their own Part B premiums.

Other States may simply believe buying-in is not cost-effective because of the type of care their dual eligibles are likely to need. For example, States with a large group of dual eligibles in custodial long-term care may find the Part B premium costs greater



Exhibit 5-23

High, Low & Mean Per Capita Savings Associated with Buying-in,  
by States Grouped by Buy-in Agreements: 1978

AGED BUY-INS	# States* w/Complete Data	High State	Low State	Mean State (Unweighted)
Agreement includes:				
CN-cash only	15	\$298	\$138	\$198
CN-cash plus CN-no cash	9	\$443	\$179	\$246
CN-cash; CN-no cash plus MN	9	\$478	\$194	\$327
DISABLED BUY-INS				
Agreement includes:				
CN-cash only	10	\$778	\$142	\$318
CN-cash plus CN-no cash	8	\$605	\$138	\$356
CN-cash; CN-no cash plus MN	6	\$971	\$118	\$465

\* Included only those states for which corresponding buy-in cost data were available.

than the returns. Persons in long-term custodial care could require long-term premium payments, but could use very few Part B physician and outpatient services. Since long-term care recipients tend to be disproportionately non-cash enrollees, some States could reasonably exclude non-cash Medicaid enrollees from buy-in agreements.

Nevertheless, the numeric analysis suggests these buy-in decisions deserve a closer look. The fact that all States saved money by buying-in, especially those with the most comprehensive buy-in agreement, suggests that some States could do well to expand their buy-in agreements to cover non-cash Medicaid enrollees.

Future research should examine State buy-in experiences more closely, in particular, focusing on the differences in health care utilization patterns between medically needy and categorically needy dual eligibles. A survey of State buy-in officials could also provide important information that simple numeric analyses might miss.

#### 5.4 Summary of Findings on Dual Enrollees and Buy-in Decisions

In general, it has proven extremely difficult to identify, count, and thus analyze the group of persons who are dually eligible for or enrolled in Medicare and Medicaid. Currently available data bases have, however, provided reasonable -- if not perfect -- information about certain aspects of dual enrollees and State buy-in decisions.

Best estimates of the population, derived from diverse data sources, reveal that aged dual enrollees numbered roughly 2.8 million in 1978, forming roughly 11% of aged Medicare Part B enrollment and 83% of aged Medicaid recipients.

Aged dual enrollees differed from their aged Medicare-only counterparts in several key respects. For example, they were on average older and in poorer health, with disproportionately more women and minorities than the aged Medicare-only population. Perhaps more interesting is the fact that they were also much more frequent and costly users of health care than other aged health insurance groups, particularly with respect to inpatient and ambulatory care. Though age and poor health may be partly responsible for high utilization and expenditure patterns among aged dual enrollees, there appear to be other (not yet identified) factors involved. Nevertheless, in spite of the fact that aged dual enrollees incurred higher total health care costs per capita than other insured groups of aged (\$3,016 per year), they incurred smaller out-of-pocket expenses than other aged groups (\$233 per year).

Disabled dual enrollees were a much smaller population than aged dual enrollees, numbering 0.5 million in 1978. They composed roughly 21% of disabled Medicare Part B enrollment and 20% of disabled Medicaid enrollment. Unlike aged dual enrollees, they did not form the vast majority of corresponding Medicaid enrollment.

Compared to disabled Medicare-only enrollees, disabled dual enrollees were generally younger, with disproportionately more women and minorities. In contrast, compared to all disabled Medicaid recipients in New York (the only State for which person-based data were available), disabled dual enrollees were older, with a disproportionately high share of medically needy recipients.

It was not clear from the data whether disabled dual enrollees were consistently high users of health care. Disabled dual enrollees did have higher Medicare expenditures per capita than the disabled Medicare-only population. But national data describing Medicaid expenditures and utilization were not available. In the absence of information on health care expenses covered by other payors, it was therefore difficult to conclude that disabled dual enrollees were consistently high users of health care.

Perhaps the most interesting finding on dual enrollees related to the costs and returns associated with State buy-in decisions. Data on 33 States suggested that all States which elected to buy-in their dual eligibles saved money by buying-in, i.e., the returns exceeded the costs. Moreover, the savings were greatest for those States with the most comprehensive buy-in agreements -- which covered both the medically needy and the categorically needy.

In light of this evidence, it therefore seemed surprising to observe that only 27 States currently purchase Medicare coverage for all their dual eligibles on Medicaid. Either States were not aware of the savings this analysis suggests is possible, or they had reasons for limiting or avoiding buy-in agreements which were not captured by this limited numeric analysis.





## Chapter 6

### CURRENT MEDICAID PROGRAM CHANGES

Since its inception in 1965, the Medicaid program has undergone considerable legislative and regulatory change. While many of the changes in the early years were designed to expand the scope of the program, the legislation of the 1980s has focused almost entirely on steps to reduce program expenditures and exercise greater control over program growth.

Changes undertaken by Congress in the past three years have had two general themes. First, Congress has moved to substantially increase States' flexibility in determining the structure and policies of their Medicaid programs with the expectation that States will use this flexibility to help control costs. Second, Congress has mandated several direct changes to the program, including a reduction in the rate of Federal financial participation, to slow the cost spiral. Though some of the recent changes constrain State options and may add to program costs, the overall emphasis of recent federal legislation is on State flexibility and cost containment.

This chapter examines the Federal Medicaid legislation from 1980 to the present, focusing on three acts:

- The Omnibus Reconciliation Act of 1980 (ORA)
- The Omnibus Budget Reconciliation Act of 1981 (OBRA)
- The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

These legislative initiatives are described briefly in Section 6.1, with special emphasis given to those elements related to State flexibility and cost containment.

Sections 6.2 through 6.6 provide a more in-depth analysis of the legislation in five areas of major interest to policymakers:

- 1) Reducing institutional costs: home and community-based care waivers

- 2) Containing provider costs: changes in hospital reimbursement
- 3) Increasing cost-consciousness and restricting enrollees to efficient providers: freedom-of-choice waivers
- 4) Reducing inappropriate utilization: the use of copayments
- 5) Deciding whom to serve: State eligibility provisions

These sections also examine State responses to the legislation. Due to the fact that most of these State initiatives have been in place for only a couple of years (at most), this discussion is primarily descriptive rather than evaluative.

Section 6.7 addresses an additional issue of interest to policymakers -- family responsibility. Although there has not been any recent Federal legislation in this area, several States have initiated State legislation changing their family responsibility requirements for Medicaid. These developments at the State level are discussed in Section 6.7.

The final section discusses HCFA's future evaluation plans for studying the impacts of the recent Federal Medicaid legislation discussed in this chapter.

#### 6.1 Recent Legislation: 1980 - 1982

ORA introduced the first round of major Medicaid changes passed in the 1980s. Some of ORA's more significant provisions included the following:

- Authorized changes in ICF and SNF reimbursement from rates based on "reasonable costs" to rates which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities..." in order to curb institutional care costs.
- Allowed States to include the uncompensated value of property disposed of within 2 (or more) years prior to the application for Medicaid in order to discourage transfers of assets.

Other provisions revised hospital reimbursement rules to encourage philanthropic giving and to permit rural hospitals to enter into "swing-bed" agreements, where beds could be used for either acute care or long-term care under certain conditions. Exhibit 6-1 summarizes key ORA provisions related to Medicaid.

The subsequent OBRA introduced far more extensive changes than ORA, and in fact, is the most significant single piece of Medicaid-related legislation passed in recent years. OBRA's

Exhibit 6-1

Summary of Major ORA (PL 96-499 and PL 96-611) Provisions  
Related to Medicaid

RECIPIENT ELIGIBILITY

- Allowed states the option to consider, in determining Medicaid eligibility, the uncompensated value of property disposed of within 2 years prior to the application for Medicaid, or within a longer period if value of the property exceeds \$12,000.

PROVIDER ELIGIBILITY

- Relaxed requirements for SNF's re: Life Safety Code compliance.
- Extended reimbursement (and hence participation) to nurse midwives, in certain cases.
- Broadened exclusion of practitioners convicted of program-related crimes.

REIMBURSEMENT

- Outlined items which can be included in hospital operating costs.
- Allowed hospitals to be reimbursed for non-acute long-term care at appropriate SNF/ICF rates where no long-term care beds available, in certain cases.
- Permitted rural hospitals to enter into "swing-bed" agreements, i.e., to alternate bed use between acute care and long-term care.
- Limited reimbursements for independent clinical lab services.
- Authorized change in reimbursement for SNF's and ICF's from a "reasonable cost" basis to costs deemed reasonable and adequate for efficient and economically-operated facilities.

ADMINISTRATIVE

- Introduced intermediate sanction of denying reimbursement as an alternative to decertification for SNF's and ICF's not in compliance with program conditions of participation.
- Allowed criminal penalties for certain infractions.
- Extended Federal payments for state Medicaid fraud control units.
- Relaxed and added various provisions governing the membership and activities of PSRO's.
- Other miscellaneous provisions.



provisions affected several elements of the Medicaid program, such as recipient eligibility, provider eligibility, covered services, reimbursement, and administration. A detailed listing of OBRA's major elements is presented in Exhibit 6-2.

Recipient eligibility was modified by several provisions. States were given the flexibility to pick up some former AFDC eligibles under new optional categorically needy groups which were added by OBRA. OBRA also restructured requirements for the medically needy program.

OBRA affected provider eligibility by allowing States to restrict the participation of providers who provided low quality or unnecessary medical care (the "lock-out" provision). It also permitted States greater freedom in selecting cost-effective providers and allowed certain providers to provide home and community-based care under Secretarial waivers.

OBRA also affected service coverage by granting States some freedom to reduce the range of services or providers available to certain Medicaid enrollees. Other provisions relaxed requirements surrounding services for the medically needy and limited or eliminated payments for certain drugs and lab tests. However, OBRA 1981's most significant change in service coverage was probably the provision to allow States to provide home and community-based care through the Medicaid program as a less costly alternative to institutionalization.

Medicaid reimbursement policies were also dramatically affected by OBRA. It limited or eliminated payments for certain drugs and lab tests. More important was a provision changing reimbursement for hospital care from a "reasonable-cost" basis to rates based on costs deemed "reasonable and adequate" for "efficiently and economically-operated facilities."

Finally, OBRA introduced a variety of administrative changes, including civil monetary penalties for fraudulent claims and reduced Federal matching payments to keep Medicaid expenditures down.

TEFRA, in contrast, was far less comprehensive than OBRA in its Medicaid reforms. Nevertheless, it introduced a few important changes, summarized in Exhibit 6-3. For example, it permitted the imposition of "nominal" copayments on certain mandatory services for specified groups of the categorically needy. It also granted States the power to impose liens on the real property of institutionalized enrollees, and extended optional coverage to disabled children living at home.



Exhibit 6-2

Summary of Major OBRA (PL 97-35) Provisions Related to Medicaid

RECIPIENT ELIGIBILITY

- Restructured requirements for medically needy program to allow states to offer more limited coverage.
- Eliminated mandatory Medicaid coverage of AFDC-related children 18-20 years of age not in school.
- Restructured some requirements for coverage of non-AFDC poor children.
- Added some optional categorically needy groups.

PROVIDER ELIGIBILITY

- Allowed states greater flexibility to restrict recipient freedom-of-choice of provider; possible options include competitive bidding, lock-in, lock-out, and a variety of options under Secretarial waiver authority.
- Increased flexibility in prepaid provider (HMO) participation in state plans.

SERVICES

- Modified requirements governing services for the medically needy.
- Allowed provision of home and community-based care services under Secretarial waiver.

REIMBURSEMENT

- Authorized change in reimbursement for hospital services from a "reasonable cost" basis to costs deemed reasonable and adequate for efficiently and economically operated facilities; modified this to accommodate hospitals serving disproportionate numbers of low-income patients with special needs.
- Repealed 80% occupancy test for long-term care rates to hospitals with patients receiving non-acute care; replaced it with an excess bed test.
- Limited payments for certain drugs.

Exhibit 6-2  
(cont'd)

REIMBURSEMENT (cont'd)

- Eliminated Federal matching for certain laboratory tests.
- Repealed requirement that Medicaid payments to physicians and laboratories cannot exceed Medicare "reasonable charges."
- Other miscellaneous provisions.

ADMINISTRATIVE

- Authorized civil monetary penalties
- Decreased Federal matching payments to states, but also allowed offsets in the reduction for states which kept Medicaid spending below 109% of FY 1981 expenditures, and for states meeting certain other conditions.
- Required Secretary to act on plan amendments and waiver-of-plan-requirement requests within 90 days.
- Repealed EPSDT penalty.
- Other miscellaneous provisions.

Exhibit 6-3

Summary of Major TEFRA (PL 97-248) Provisions Related to Medicaid

RECIPIENT ELIGIBILITY

- Allowed states the option to deny Medicaid eligibility for 24 months or more to persons who disposed of their homes for less than fair market value within 24 months prior to their institutionalization.
- Extended coverage to disabled children living at home.

SERVICES

- Allowed states the option to impose "nominal" copayments on mandatory services for the categorically needy, subject to certain limitations. Copayments were prohibited in the following cases:
  - children under 18 (or under 21, at state option)
  - pregnancy-related services (or all services for pregnant women, at state option)
  - patients in a SNF or ICF
  - categorically needy persons enrolled in an HMO (or both categorically needy and medically needy in HMO's, at state option)
  - emergency and family-planning services

ADMINISTRATIVE

- Permitted states to impose liens on the real property (including homes) of institutionalized enrollees expected to spend the rest of their lives in institutions, subject to certain constraints.
- Modified penalties in Federal matching payments to states with high error rates.
- Other miscellaneous provisions.

The impact of this recent Federal legislation on State Medicaid programs is difficult to assess. Because the legislation itself is so recent, State initiatives authorized by the legislation are also quite new. Data describing State initiatives are still somewhat sparse, though La Jolla Management Corporation expects to have 1983 profiles of each State's program ready before the end of the year.

The data that are available, however, suggest that several important changes have been implemented or are underway in several important areas of interest to policymakers: home and community-based care, hospital reimbursement, freedom-of-choice waivers, copayments, and State eligibility provisions. State initiatives in each of these areas are examined in the following sections.

## 6.2 Home and Community-Based Services Waivers

Of all the provisions of OBRA, none has initiated greater activity and policy interest than Section 2176: Home and Community-Based Services Waivers. Section 2176 was included as an OBRA provision in response to rapidly rising expenditures for nursing home care and in recognition of the need for alternative long-term care policies.

The Section 2176 waiver program recognizes that there are a substantial number of Medicaid recipients in nursing homes who neither want nor need to be there. Further, given that the nursing home recipients comprise only 7.3% of the Medicaid population, but account for at least 43% of all expenditures, the waiver program recognizes that substantial savings could potentially be accrued by diverting or deinstitutionalizing persons from nursing homes. By allowing Medicaid financing of non-medical long-term care services to dependent aged and disabled persons in non-institutional settings, and by giving States the requisite tools to target these services effectively, the 2176 waiver program represents a major policy initiative in long-term care financing.

Under Section 2176, States may apply to HCFA to cover almost any array of home and community-based services which States believe are needed to maintain persons at risk of institutionalization in community settings. Commonly requested waiver services include those which have traditionally been funded under the Title XX Social Services Block Grant, such as case management, homemaker services, respite care, and so on. The only restrictions on service coverage are that room, board, and vocational training cannot be financed through the waiver. Services must be provided by certified providers and States must institute mechanisms of quality assurance for community-based services.



The Section 2176 waiver also addresses some of the biases toward institutional care prevalent within Medicaid eligibility provisions. Specifically, States may also request a waiver to provide community-based services to persons not receiving SSI cash assistance, with incomes up to 300% of the Federal payment standard. This provision allows States to provide assistance to persons who would otherwise not be eligible for Medicaid unless they were institutionalized. Second, States may request a waiver of deeming provisions for non-institutionalized persons to be equivalent to deeming provisions for the institutionalized.<sup>44</sup>

While the prospect of containing long-term care costs by diverting and deinstitutionalizing persons from nursing homes who can be more appropriately, and less expensively, cared for in community settings is an inviting one, there is also the more disconcerting prospect that the financing of home and community-based care under Medicaid will accelerate Medicaid expenditures, with little or no effect on containing nursing home costs. The key issue in the 2176 waiver program is whether States effectively target services to those who would otherwise be admitted to nursing homes. Recognizing the risk of program expansion, HCFA built several mechanisms into the 2176 waiver program to ensure that the program adheres to its cost-containment objectives. First, waiver approval is contingent on States demonstrating in their waiver applications that aggregate Medicaid expenditures under the waiver will be less than aggregate Medicaid expenditures without the waiver. By definition, this means that States must demonstrate that all expenditures for home and community-based services will be more than offset by reduced expenditures for other covered services.

A second provision of the 2176 waiver program to ensure its cost containment objectives is the requirement that all applicants for home and community-based care undergo an individual assessment prior to their participation, and that waiver services be provided only to these persons who would otherwise require the level of care provided in an ICF or SNF. Beyond this general requirement, however, States have been given broad leeway in how to define ICF or SNF level of care criteria, what assessment instruments to use, and in how to conduct such assessments. Operationally, therefore, HCFA is delegating the responsibility for the effective targeting of 2176 waiver services to the States themselves.

Third, 2176 waiver program regulations permit States to impose additional restrictions to improve service targeting. States may request a waiver of statewideness, and implement the waiver program

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<sup>44</sup>In most States, Medicaid cannot deem the income of a spouse or parent of an institutionalized applicant beyond the first month of institutionalization.

in only limited geographical areas, so as to slowly develop program capacity and/or to monitor waiver program implementation closely. Under a freedom-of-choice waiver, States may also choose to deny home and community-based services to persons for whom community-based care would be more expensive than institutional care. States may also impose limits on the comparability of services, so that services provided under the waiver need not be comparable for all individuals within an eligibility group. In essence, the HCFA's stated objective is to "give the States the maximum opportunity for innovation in furnishing non-institutional services to beneficiaries." Thus, on the one hand, the 2176 waiver program departs markedly from the entitlement philosophy of the overall Medicaid program, but, on the other, recognizes that the only way to make home and community-based services cost-effective is to institute mechanisms to target services to those persons who would otherwise require more expensive care.

Finally, HCFA also plans to conduct intensive evaluations of the 2176 waiver program to assess its impacts. Participating waiver States are required to submit annual reports on program enrollment, utilization of waiver services (by type of service), and expenditures for waiver program clients, as well as institutionalized persons not covered under the waiver. HCFA has also contracted for a three-year evaluation effort to independently assess the impacts of the 2176 waiver program. The results of both HCFA's internal and independently-contracted evaluations will be used to guide future policy decisions on the financing of home and community-based care in the Medicaid program.

#### State Responses to the 2176 Waiver Program

State responses to Section 2176 have exceeded all expectations. As of December 9, 1983, 47 States had submitted 105 waiver requests, 62 of which had been approved, 10 of which had been disapproved or withdrawn, with the remaining 32 requests still pending at that time. Exhibit 6-4 summarizes the 43 waiver programs in 33 States approved as of July 11, 1983. In total, these 33 States were planning to service about 62,000 persons in the first year of operation.<sup>45</sup> This compares to a total institutionalized Medicaid population of about 1.5 million recipients, and 396,000

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<sup>44</sup>"Medicaid Program: Home and Community-Based Services." Federal Register 46 (190): 48532-48542, October 1, 1981.

<sup>45</sup>However, preliminary State reports indicate that most States were not meeting their enrollment targets.

Exhibit 6-4

Summary of 2176 Waiver Proposal Approved as of July 11, 1983

Waivers Approved	43
States with Approved Waivers	33

Target Population Covered

Aged	4
Aged/Disabled	10
Mentally Retarded/Developmentally Disabled	12
Mentally Ill	3
Physically Disabled	1
Combined Populations	13

Other Waivers Requested

Freedom of Choice	3
Statewideness	34
Comparability	40
Other	4

Eligibility

SNF or ICF	32
ICF/MR	25
300% Income Limit	16
Medically Needy Included	14
Specific Target Group	20

Services Covered

Adult day	30
Case Management	37
Respite Care	26
Habilitation & Training	20
Personal Care	17
Homemaker	21
Home Health	11
Transportation	17
Therapy	9
Chore	5
Nutrition and Dietary Counseling	9
Psychological Services	3
Minor Adaptations to Home	10
Residential Support Services	5
Additional Services	23

Waiver Population (1st Year)

Largest program (Florida)	12,572
Smallest program (Hawaii)	28
Median program (West Virginia)	463



recipients of home health services (mostly in New York), in 1982. Most States were planning to begin with small programs -- the majority anticipated serving fewer than 500 persons in the first year -- and only six States were planning to implement waiver programs statewide. It is clear that most States, while interested in the cost-saving potential of the waiver program, are at the same time approaching the implementation of the program conservatively.

A wide array of services are being offered by States, although the most commonly provided services are adult day care, case management, and respite care. Many States are also using the waiver to provide services which were previously permitted as State options (personal care, nursing care), but are using other waiver provisions to limit these services only to targeted groups.

Also noteworthy is the large number of waiver programs being targeted to the mentally retarded/developmentally disabled populations, although this is not surprising when one considers the high costs of ICF-MR care -- which averaged over \$23,000 per recipient per year in 1982 -- and therefore the potential for achieving cost-savings by reducing utilization of ICF-MRs.

Finally, it is also apparent that States are taking advantage of the opportunity to design innovative waiver programs. There is wide diversity in States' strategies to utilize the waiver cost-effectively, and many States are using the program in combination with existing community-based programs to enhance its effectiveness. For example, Minnesota is not only screening nursing home applicants who would be eligible for Medicaid immediately upon admission, but also applicants who would be eligible within 180 days of their admission (after spending down their assets), and providing community-based services to these "180-day eligibles" solely from State and local funds. New Jersey requested and received a special waiver to limit the program to persons between 100% and 300% of the SSI-Federal payment standard (New Jersey does not have a medically needy program) and to limit service coverage only to the waived services, not other Medicaid services covered in the State plan. While the diversity across waiver programs makes for interesting experimentation, it at the same time makes the evaluation of the program's cost-effectiveness more problematic, particularly in discerning what program combinations are more or less effective in achieving cost savings.

### 6.3 Inpatient Hospital Reimbursement

Reimbursement for inpatient hospital services is an issue of major importance because of the high percentage of Medicaid expenditures which it represents. In FY 1982, inpatient hospital



services accounted for almost a third of total Medicaid expenditures, roughly \$7.8 billion. To help bring hospital costs under control, OBRA granted States new flexibility in the establishment of inpatient hospital reimbursement methodologies, with the expectation that States would use this flexibility to facilitate cost savings. Prior to the enactment of OBRA, State Medicaid programs were required to pay for inpatient hospital care using one of two standards: Medicare reasonable cost-based standards or alternative cost-based standards approved by the Secretary. Reimbursements based on "reasonable costs" allowed hospitals considerable freedom to incur costs and pass those costs on to the Medicare and Medicaid programs.

Section 2173 of OBRA changed reasonable cost-based reimbursement by allowing States to apply somewhat stricter reimbursement methodologies. Hospitals could now be reimbursed for only those costs which were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." Congress hoped this provision would help States to curb dramatic increases in Medicaid expenditures for hospital care.

Section 2173 imposed three conditions on this new reimbursement policy. First, payment rates had to take into account the situations of hospitals serving a disproportionate number of low-income persons with special needs. Second, payment rates for inpatient stays requiring lower levels of care had to be consistent with "swing-bed" provisions of Section 1861 of the Social Security Act. Finally, payments had to be sufficient to ensure that recipients had reasonable access to inpatient care of adequate quality.

#### State Responses to OBRA Hospital Reimbursement Changes

1982 Program Characteristics Data compiled by La Jolla reveal that, as of early 1982, 17 States had departed from Medicare reasonable cost-based methods to alternate reimbursement methods. But of these 17, only 4 changed reimbursement using Section 2173 authority: Illinois, Kentucky, Missouri and North Carolina. The other 13 had changed methods under other authority, including HCFA demonstration authority. Preliminary 1983 Program Characteristics data suggest more States have taken advantage of 2173 authority to move to prospective reimbursement systems, but precise numbers were not available in time for this report.

Equally if not more dramatic changes in hospital reimbursement have taken place outside 2173 authority. The most talked about changes in recent months are underway in California, in its new

Selective Provider Contracting Program (SPCP) (Zimmerman, 1983). Health care reforms passed by the State legislature in 1982 led to the following changes:

- authorized the appointment of a special hospital negotiator (informally referred to as "Czar") who would act as prudent purchaser for all inpatient hospital services for Medi-Cal enrollees; eventually the Office of the Special Hospital Negotiator would be replaced by a California Medical Assistance Commission
- authorized the Department of Health Services to enter into selective contracts with non-institutional providers
- authorized private insurance companies and non-profit hospital plans to selectively contract with Preferred Providers, and to restrict policy holders to services rendered through these providers.

Though the changes have tremendous implications for the overall health care market in California, initial steps have focused on hospital reimbursement.

In 1982, a Special Hospital Negotiator (Mr. William Guy) was appointed for a one-year term to act as prudent purchaser of all inpatient hospital services for the Medi-Cal population. All hospitals wishing to participate in the Medi-Cal program were required to negotiate a contract with the Special Negotiator. Exceptions could be made in only special cases.

The Special Negotiator was directed to consider several factors in determining whether to award a contract to a hospital:

- beneficiary access
- utilization controls
- ability to render services efficiently and economically
- ability to arrange for specialty services
- fraud and abuse protections
- factors which reduce cost, promote access, and enhance quality of care
- existing labor-management agreements

The Negotiator was free, however, to weight these factors as he chose. As a result, contracts reflected, in large part, the preferences of the individual Special Negotiator. Though the terms of specific contract awards were confidential, Mr. Guy publicly indicated a preference for fixed-price rates per day, unadjusted by case or service mix, and for hospitals providing a full range of services.

In July 1983, a newly created California Medical Assistance Commission assumed the powers and functions of the Office of the Special Negotiator. Its task is to establish an administrative and institutional framework for the contracts awarded selected hospitals in the Medi-Cal program.

Though it is, perhaps, too soon to tell what the impact of this reform in California will have on hospital costs, one observer feels "it is abundantly clear that significant reduction in hospital costs will be achieved...in the near term" (Zimmerman, 1983).

HCFA plans a direct evaluation of recent State changes in hospital reimbursement policies as part of its Long-Term Evaluation effort. California will be a major focus of this effort, although other States will be included as well. The impact of such changes on inpatient expenditures, utilization patterns, access to quality care, and provider reaction will be assessed.

#### 6.4 Freedom-of-Choice Waivers

Prior to the enactment of OBRA, Medicaid recipients were, by law, guaranteed freedom of choice of provider. This guarantee meant that recipients were reasonably free to seek health care wherever and whenever they wished among authorized Medicaid providers. Such freedom could be restricted only if the Secretary secured a waiver under Section 1115 of the Social Security Act authorizing innovations in the delivery and financing of Medicaid services.

Section 2175 of OBRA relaxed the freedom-of-choice requirement in two key ways. First, it modified Section 1915(a) of the Social Security Act so that State Medicaid programs could engage in the following activities without being out of compliance with freedom-of-choice and other<sup>46</sup> State plan requirements:

- competitive bidding arrangements or bulk/volume purchasing for laboratory services and medical devices
- "locking-out" or restricting the participation of certain providers who had provided poor quality care or medically unnecessary care
- "locking-in" certain recipients who had been chronic overutilizers by restricting their care to only specified providers.

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<sup>46</sup>Specifically, requirements for statewideness and comparability of services.



Each of these activities could be initiated by a State without Secretarial waiver approval.

OBRA also introduced a second route by which States could restrict recipient freedom of choice in order to curb Medicaid program costs. Section 2175 of OBRA modified Section 1915(b) of the Social Security Act to permit four classes of Secretarial waivers:

- 1) 1915(b)(1) waivers to implement primary care case management systems
- 2) 1915(b)(2) waivers to permit localities to act as central brokers in helping Medicaid recipients choose among competing health plans
- 3) 1915(b)(3) waivers to allow States to share with recipients, through the provision of additional services, savings resulting from the use of less costly, more cost-effective care
- 4) 1915(b)(4) waivers to restrict recipients to receiving non-emergency care from only efficient and cost-effective providers.

Freedom-of-choice waivers are generally granted for up to 2 years. States may, however, request a continuation beyond 2 years.

TEFRA modified the OBRA provisions somewhat. OBRA had permitted waivers under Section 1903(m) of the Social Security Act, the section governing Medicaid involvement with prepaid plans (HMO's). This section essentially gave States considerable flexibility in contracting with prepaid plans. TEFRA, however, disallowed waivers under these flexible requirements, thereby preventing States from ignoring "minimal" protections outlined in section 1903(m). But by the time TEFRA took effect, 5 States already had approved waivers which did not meet TEFRA requirements. These waivers were allowed to stand.

#### State Response to the Freedom-of-Choice Waivers

As of June 15, 1983, the Intergovernmental Health Policy Project reported that 22 States submitted a total of 47 waiver applications related to the freedom-of-choice provisions. Of these 47 applications, 25 were approved, 7 were pending, and 14 were either withdrawn or denied. Approvals were granted to only 13 of the 22 States applying. These applications are summarized in Exhibit 6-5.



## Summary of Freedom-of-Choice Waiver Activity (Section 217's) as of June 15, 1983

State	Status	Project Type	Waiver Section	Area
CA	W	Community-based organization to serve needs of aged people	1915(b)(1)	San Francisco
	A	Selective Provider Contracting Program. Allow the Medi-Cal Program to selectively contract for inpatient hospital services with cost-effective facilities	1915(b)(4)	
	P	Consolidation of Medi-Cal mental health services into existing Short-Doyle systems	1915(b)	
	A	PCCM-Primary Care Case Management. Primary care provider selects most cost-effective and appropriate treatment	1915(b)(1)	4-6 sites
	P	Permit implementation of guaranteed enrollment for new AFDC enrollees in HMO	1915(b)(1)	Contra Costa County
CO	P	State would contract with counties for provisions of health services	1915(b)(1) 1915(b)(4)	
	A	Enroll recipients in HMO	1915(b)(1)	Mesa County
	A	Recipients select primary care physician as case manager	1915(b)(1)	Statewide
	D	Make Selection of PCP an eligibility requirement. Addendum to case-management waiver	1915(b)(1)	
	D	Impose larger copayment on transportation than now allowed	1915(b)(3)	
CT	D	Waive comparability and maximum copay requirements to allow copay on medical transportation when cost of trip is under \$10	1915(b)(3)	
	P	Case-management dental program	1915(b)	4 counties
HI	W	Allow state to provide Kaiser HMO with list of AFDC eligibles for marketing purposes		Statewide
KS	P	Physician, case management	1915(b)(1)	One rural, one urban
KY	A	Citicare-Health insuring organization. Recipient selects primary care provider	1915(b)(1) 1915(b)(3) 1915(b)(4)	Louisville and Jefferson Counties
ME	D	Impose \$.50 copayment to prescription drugs excluding nursing home residents	1915(b)	
MA	A	Offer a choice of primary care providers to recipients	1915(b)(1)	Statewide
	W	CHCC-State to contract with a nonprofit at-risk coordinate organization to establish case-management network	1915(b)	Boston

Exhibit 6-5  
(continued)

State	Status	Project Type	Waiver Section	Area
MI	A	Capitated Ambulatory Program-Offer choice of primary care provider to all recipients	1915(b)(1)	Statewide
	A	Addendum to Cap. Amb. Waiver to allow phase-in of the program rather than initial state-wide implementation	1915(b)(1)	
	A	To extend Cap. Amb. Program 1 year except 1903(m) provision	1915(b)(1)	
	A	Primary Mental Clinic Sponsor Program-Case manager-Community Mental Health Board	1915(b)(1) 1915(b)(4)	Statewide
	A	Restrict HMO Disenrollment	1915(b)(4)	Statewide
	A	Primary Care Physician Sponsor Program-Enrollment of recipients with primary care physician	1915(b)(1)	Wayne County
MS	D	Establish limit of 100 nursing home beds per 1,000 aged, blind, or disabled recipients	1915(b)	Statewide
NE	W	Impose reimbursement and time limits on delivery of psychiatric services		
NH	D	Provide services to institutionalized recipients even then they they exceed limits for the noninstitutionalized. Impose copay of \$10 on hospital outpatient services, \$3.50 on prescriptions.	1915(b)(3)	
	A	Case management-require enrollment in one area in one HMO (Matthew Thornton Health Plan)	1915(b)(1)	Served by Nashua DO
NY	A	Restrict HMO disenrollment for 5 months following first 30 days of enrollment	1915(b)(1)	Statewide
	P	Limit provision of psychological services to mental health clinics	1915(b)(4)	Statewide
NC	A	Case management	1915(b)(1) 1915(b)(3)	Durham, Wake and Edgecombe Counties
OH	W	Permit state to exempt person enrolled in HMO with risk contract from copy that would otherwise be imposed on all optional services	1915(b)(3)	
PA	P	Restrict high utilizers to a primary care physician responsible for authorizing services	1915(b)(1)	Statewide
	A	Enroll recipients with primary care providers	1915(b)(1)	4 primary care centers
TN	A	Primary care case management	1915(b)(1)	Maury County, Memphis
	A	Health insuring organization	1915(a) 1915(b)(1) 1915(b)(3)	

Exhibit 6-5  
(continued)

State	Status	Project Type	Waiver Section	Area
UT	A	Recipients select primary care providers	1915(b)(1)	Statewide
	A	Provider Contracting-Hospital inpatient services contracted	1915(b)(4)	Phased-in
WA	D	Waive certain nursing home utilization control & review activities	1915(b)(1)	
	D	Impose \$5 copay on emergency room and outpatient services for all except institutionalized recipients	1915(b)(1)	
	A	Establish prepaid capitation for prescription drugs for nursing home residents	1915(b)(4)	Statewide
WV	W	Primary care, case management	1915(b)(1)	
WI	D	Waive prospective budgeting requirement	1915(b)(1)	
	A	Primary care case management for beneficiaries not enrolled in HMO	1915(b)(1)	begin in 4 counties
	A	Gatekeeper-Mental Health boards purchase in- and outpatient mental health services	1915(b)(4)	Statewide
	A	Require recipients to enroll in prepaid health plan	1915(b)(1)	
	A	Exempt HMO enrollees from copays; provide additional services to medically needy nursing home residents; phase out 2 lowest levels of ICF care	1915(b)(3)	

\* Only that portion of request seeking to exempt HMO enrollees from copayment was approved; other sections were disapproved.

A = Approved

P = Pending

D = Denied

W = Withdrawn

SOURCE: Excerpts from table produced by IHPP and NCSL in State Health Notes, 1983.

Of the 25 approved waivers, the vast majority (19) involved Section 1915(b)(1) authority governing primary care case management. Only 4 involved 1915(b)(3) authority regarding shared savings, and 7 involved 1915(b)(4) authority which restricted recipients to efficient and cost-effective care. No waiver involved 1915(b)(2) activity covering central brokers, and several waivers included more than one type of waiver authority.

The 19 waivers involving primary care case management were awarded in the following States (with the number of waivers in each State in parentheses):

California (1)	New York (1)
Colorado (2)	North Carolina (1)
Kentucky (1)	Pennsylvania (1)
Massachusetts (1)	Tennessee (2)
Michigan (5)	Utah (1)
New Hampshire (1)	Wisconsin (2)

Nine of these 19 waivers were statewide; the rest were implemented in selected sites or were scheduled to be phased-in over a period of time.

The 4 waivers involving shared savings with recipients were approved in the following 4 States:

Kentucky (1)	Tennessee (1)
North Carolina (1)	Wisconsin (1)

These efforts generally occurred alongside other 2175 waiver activity in these States, especially primary care case management activity.

The 7 waivers which involved restricting recipients to efficient and cost-efficient providers were approved in 6 States:

California (1)	Utah (1)
Kentucky (1)	Washington (1)
Michigan (2)	Wisconsin (1)

Four of these were statewide, 1 was phased-in, and 1 was applied in only selected counties. (Information on the seventh was not provided in the IHPP report.) In all but one State, these waivers occurred alongside other 2175 waiver activity. Included among these 1915(b)(4) waivers is the waiver authorizing California's Selective Provider Contracting Program, described earlier in this chapter.

In sum, the OBRA provision allowing freedom-of-choice waivers appears to have generated changes in at least 13 States to date, primarily in the area of primary care case management. Data do not



yet permit an evaluation of the impact of these changes on Medicaid program costs, but one of HCFA's recently awarded Long-Term Evaluation Contracts will address this issue area over the next few years.

#### 6.5 Copayments

In an attempt to increase cost-consciousness among Medicaid recipients, TEFRA allowed States to extend limited copayment requirements for certain services to the categorically needy. Prior to TEFRA, States were allowed to impose nominal copayments on (1) optional services for both the categorically needy and the medically needy, and (2) mandatory services for the medically needy only. The passage of TEFRA allowed States to extend "nominal" copayments for certain mandatory services provided to the categorically needy, though the "nominal" requirement could be waived in special situations. ("Nominal" was defined by previous regulations as between \$0.50 and \$3.00 per service.)

But while TEFRA expanded the potential use of copayments, it also explicitly prohibited the application of copayments in the following situations:

- 1) for categorically and medically needy persons under age 18 (or under age 21, at State option)
- 2) for categorically and medically needy patients in ICFs and SNFs
- 3) for categorically needy enrollees in HMO's (or for both categorically and medically needy enrollees, at State option)
- 4) for services related to pregnancy (or for all services provided to pregnant women, at State option)
- 5) for emergency and family planning services.

#### State Response to TEFRA Copayment Provisions

Preliminary State Program Characteristics data for March 1983 reveal that 25 States including the District of Columbia had copayments of one form or another. These copayments were applied most frequently to drug purchases (19 States), but were also applied to a variety of other services, such as optometrist, chiropractor, and outpatient services. Exhibit 6-6 lists the services subject to copayments.

Currently available data, however, do not identify those copayments enacted as a result of TEFRA. Most of the copayments in effect in March 1983, were, in fact, in effect prior to TEFRA. As

Exhibit 6-6

Services Subject to Copayments As of March 1983\*  
(Number of States in parentheses)

Drugs	(19)
Dental	(10)
Optometrist	(8)
Outpatient	(6)
Podiatrist	(6)
Chiropractor	(6)
Eyeglasses	(5)
Dentures	(5)
Prosthetic Devices, Selected	
(e.g., hearing aids, orthopedic shoes)	(5)
Inpatient, Selected**	(5)
Physician	(3)
Clinic	(3)
Transportation, Selected	(3)
Speech, Hearing, or Language	(3)
Psychologist	(2)
Medical Equipment/Supplies	(2)
Rehabilitation	(2)
Physical or Occupational Therapy	(2)
Emergency Room, Selected	(1)
Optician	(1)
ICF, Selected	(1)
SNF, for those under 21	(1)

\* Information on one State not available; information on 6 States tentative.

\*\* 1 State with a \$30 deductible not included.

SOURCE: Preliminary 1983 Program Characteristics data released by La Jolla Management Corporation.

of March 1983, only 4 States appeared to have added copayments on mandatory services for the categorically needy. And it is difficult to infer from existing data whether these copayments were enacted under TEFRA authority, since most of these new copayments exceeded "nominal" levels and may have required special waivers. Illinois, for example, imposed a variable copayment on inpatient hospital services for the categorically needy. Missouri imposed a \$10.00 copayment on inpatient hospital care and a \$3.00 copayment on outpatient care for the categorically needy. South Dakota imposed a \$25.00 copayment on inpatient hospital stays, and a 5% cost-sharing requirement on outpatient care for the categorically needy. And Wisconsin adopted a \$75.00 copayment requirement for inpatient hospital stays for mental disease, and a variable copayment for outpatient care for the categorically needy. In Illinois, South Dakota, and Wisconsin, these specific changes coincided with other copayment extensions. In Missouri, these changes were part of other reforms which extended some and eliminated other copayments.

In sum, currently available data do not yet identify which States have imposed copayments directly in response to TEFRA. Nevertheless, it appears TEFRA has not yet generated massive changes in State copayment schedules. As of March 1983, less than a handful of States had imposed copayments which could have been authorized by TEFRA.

In addition, it is difficult to discern an overall trend in the use of copayments (TEFRA-related and others) by State Medicaid programs. From February 1982 to March 1983, 6 States added copayments, 4 States eliminated copayments, and 3 States both added and subtracted copayments. These changes, summarized in Exhibit 6-7, suggest that States are still experimenting with copayment provisions. They may not be uniformly convinced of the desirability or effectiveness of such provisions.

An evaluation of copayments will be the subject of one of HCFA's Long-Term Medicaid Evaluation contracts over the next three years. The evaluation will determine the effects of copayments on utilization and expenditures.

## 6.6 Eligibility

Medicaid eligibility policies have been a recurring subject for legislative change in the 1980s. Each of the three major pieces of Medicaid legislation through 1982 have included changes that relate to eligibility provisions.

ORA allowed States to take into account the value of property transferred by individuals in the two years prior to Medicaid application. This option permitted States to deny Medicaid

Exhibit 6-7

Summary of Cost-Sharing (including copayments) in 51 States: February 1982 and March 1983

FEBRUARY 1982						MARCH 1983				
STATE	SERVICE	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS	SERVICE*	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS
AL	Drugs	CN	\$ .50		No MN Program	Drugs	CN	Variable		No MN Program
AK	None					None				
AR	Drugs	CN & MN	\$1.00			None				
CA	Drugs	CN & MN	\$1.00			Drugs	MN	\$1.00		
	Emergency Room	CN & MN	\$5.00		For Inappropriate Use	Emergency Room	MN	\$5.00		For Inappropriate Use
	Outpatient Hospital	CN & MN	\$1.00			Outpatient Hospital	MN	\$1.00		
CO	None				No MN Program	(None)				No MN Program
CT	None				No MN Program	(None)				No MN Program
DE	None				No MN Program	None				No MN Program
DC	Drugs Eyeglasses	CN & MN CN & MN	\$ .50 \$2.00			(Drugs) (Eyeglasses)	CN & MN CN & MN	\$ .50 \$2.00		
FL	Dentures Prosthetic Devices --Hearing Aids	CN  CN	5%  5%		No MN Program	Dentures Prosthetic Devices - Hearing Aids	CN  CN	5%  5%		No MN Program
GA	Drugs Podiatrist Prosthetic Devices Other Practitioner --Psychologist Transportation	CN CN CN  CN CN CN	Variable <sup>4/</sup> Variable <sup>4/</sup> Variable <sup>4/</sup>  Variable <sup>4/</sup> Variable <sup>4/</sup> Variable <sup>4/</sup>		No MN Program	None			11/1/82	No MN Program
HI	Dental None	CN	Variable <sup>4/</sup>			None				
ID	Drugs	CN	\$ .50		No MN Program	None			4/83	No MN Program
IL	None					Inpatient		Variable <sup>4/</sup>		No MN Program
IN	None				No MN Program	None				No MN Program

\* Reports on 1983 copayments have not yet been received for states with items in parentheses, so these copayments could change.

SOURCE: Program Characteristics Data, preliminary tabulations by La Jolla Management Corp.



STATE	FEBRUARY 1982					MARCH 1983				
	SERVICE	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS	SERVICE*	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS
IA	Dental	CN	\$3.00		No MN Program	Dental	CN	\$3.00		No MN Program
	Prosthetic Devices	CN	\$2.00			Drugs Prosthetic Devices	CN	\$50		
	--Hearing Aids	CN	\$3.00			--Hearing Aids	CN	\$3.00		
	Optometrist	CN	\$2.00			--Orthopedic Shoes	CN	\$2.00		
	Podiatrist	CN	\$1.00			Optometrist	CN	\$1.00		
	Chiropractor	CN	\$50			Podiatrist	CN	\$50		
	Other	CN	\$2.00			Chiropractor	CN	\$50		
	Practitioner					Other				
	Physical Therapy	CN	\$50			Practitioner	CN	\$2.00		
	--Medical Equipment & Supplies	CN	\$2.00			--Psychologist				
KS	Transportation					--Medical Equipment & Supplies	CN	\$2.00		
	--Ambulance	CN	\$2.00			--Optician	CN	\$2.00		
						--All Rehabilitation Agency	CN	\$2.00		
	Chiropractor	CN & MN	\$50			(Chiropractor)	CN & MN	\$50		
	Dental	CN & MN	\$50			(Dental)	CN & MN	\$50		
	Drugs	CN & MN	\$50			(Drugs)	CN & MN	\$50		
	Optometrist	CN & MN	\$50			(Optometrist)	CN & MN	\$50		
	Other					(Other)				
	Practitioner					(Practitioner)				
	--Psychologist	CN & MN	\$50			(--Psychologist)	CN & MN	\$50		
KY	Transportation					(Transportation)				
	--Nonemergency Ambulance	CN & MN	\$50			(--Nonemergency Ambulance)	CN & MN	\$50		
	None					None				
	None					None				
LA	Drugs	CN & MN	\$50			Drugs	CN & MN	\$50		
ME	Drugs	CN & MN	\$50			None				
MD	Drugs	CN & MN	\$50			None				

\* Reports on 1983 copayments have not yet been received for states with items in parentheses, so these copayments could change.

Exhibit 6- /  
(continued)

FEBRUARY 1982						MARCH 1983				
STATE	SERVICE	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS	SERVICE*	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS
MA	None									
MI	Dental	CN & MN	\$3.00			Dental	CN & MN	\$3.00		
						Drugs	CN & MN	\$3.00		
	Optometrist	CN & MN	\$2.00			Optometrist	CN & MN	\$2.00		
	Podiatrist	CN & MN	\$2.00			Podiatrist	CN & MN	\$2.00		
	Chiropractor	CN & MN	\$1.00			Chiropractor	CN & MN	\$1.00		
MN	Prosthetic Devices					Prosthetic Devices				
	--Hearing Aids	CN & MN	\$3.00			--Hearing Aids	CN & MN	\$3.00		
	None					None				
	Dental	CN & MN	\$2.00		No MN Program	None				
	Drugs	CN	\$3.00							
MO	Eyeglasses	CN	\$3.00							
	Transportation	CN	\$3.00							
	Speech, Hearing, Language					Speech, Hearing, Language				
	--Audiology	CN	unknown		No MN Program	--Audiology	CN	Variable <sup>2</sup> / <sub>2</sub>		No MN Program
	Dental	CN	unknown			Dental	CN	5%		
MT	Dentures	CN	unknown			Dentures	CN	Variable <sup>2</sup> / <sub>2</sub>		
	Eyeglasses	CN	unknown							
	Optometrist	CN	unknown			Optometrist	CN	Variable <sup>2</sup> / <sub>2</sub>		
	Podiatrist	CN	unknown			Podiatrist	CN	Variable <sup>2</sup> / <sub>2</sub>		
						Inpatient	CN	\$10.00		
NE						Outpatient	CN	\$3.00		
						Drugs	CN	Variable <sup>2</sup> / <sub>2</sub>		
	Drugs	CN & MN	\$3.50		After 2 in 1 month Premium for MN	Drugs	CN & MN	\$3.50		
	None					None				

\* Reports on 1983 copayments have not yet been received for states with items in parentheses, so these copayments could change.

STATE	FEBRUARY 1982					MARCH 1983				
	SERVICE	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS	SERVICE*	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS
NV	Chiropractor	CN	\$1.00		Mental Health	Chiropractor	CN	\$1.00		No MN Program
	Clinic	CN	\$1.00			(Clinic)	CN	\$1.00		Mental Health
	Dental	CN	\$2.00			(Dental)	CN	\$2.00		
	Dentures	CN	\$3.00			(Dentures)	CN	\$3.00		
	Drugs	CN	\$1.00			(Drugs)	CN	\$1.00		
	Eyeglasses	CN	\$3.00			(Eyeglasses)	CN	\$3.00		
	Inpatient Mental Disease	CN	50% 1st Day		Age 65+	(Inpatient Mental Disease)	CN	50% 1st Day		Age 65+
	SNPs	CN	50% 1st Day		Under 21	(SNPs)	CN	50% 1st Day		Under 21
	PT, OT, Speech/Hearing	CN	\$1.00			(PT, OT, Speech Hearing)	CN	\$1.00		
	Podiatrist	CN	\$1.00		No MN Program	(Podiatrist)	CN	\$1.00		No MN Program
NH	Prosthetic Devices	CN	\$3.00			(Prosthetic Devices)	CN	\$3.00		
	Transportation	CN	\$3.00			(Transportation)	CN	\$3.00		
	--Ambulance	CN	\$1.00			(--Ambulance)	CN	\$1.00		
	--Taxi	CN	\$2.00			(--Taxi)	CN	\$2.00		
	--Medivan	CN	50%			(--Medivan)	CN	50%		
	ICFs	CN	50%		First Day	(ICFs)	CN	50%		First Day
	ICF-MR	CN	50%		First Day	(ICF-MR)	CN	50%		First Day
	None					Drugs	CN & MN	\$1.00		
	None					None				
	Dental	CN	\$2.00		No MN Program	Dental	CN	\$2.00		No MN Program
NJ	Drugs	CN	\$2.25			Drugs	CN	\$2.25		
	None					None				
NM										
NY										

\* Reports on 1983 copayments have not yet been received for states with items in parentheses, so these copayments could change.

Exhibit 6-7  
(continued)

FEBRUARY 1982						MARCH 1983				
STATE	SERVICE	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS	SERVICE*	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS
NC	Chiropractor	CN & MN	\$ .50			Chiropractor	CN & MN	\$ .50		
	Clinic	CN & MN	\$1.00			Clinic	CN & MN	\$1.00		
	Dental	CN & MN	\$2.00			Dental	CN & MN	\$2.00		
	Drugs	CN & MN	\$ .50			Drugs	CN & MN	\$ .50		
	Eyeglasses	CN & MN	\$2.00			Eyeglasses	CN & MN	\$2.00		Each pair & repair > \$5
	Inpatient	MN	\$2.00		For First 30 Days	Inpatient	MN			For First 30 Days
	Optometrist	MN	\$1.00		Maximum 50% of Cost	Optometrist	MN	\$1.00		
	Outpatient	MN	\$1.00			Outpatient	MN	\$1.00		
	Physician	MN	\$1.00			Physician	MN	\$1.00		
						Podiatrist	MN	\$2.00		
					Rehabilitative					
					--Nonhospital	MN	\$2.00			
ND						Dialysis				
	Eyeglasses	CN & MN	\$3.00		For second or more pair in a calendar year	Eyeglasses	CN & MN	\$3.00		For second or more pair in a calendar year
OH	None					Unknown				
OK	None					None				
OR	None				No MN Program	None				No MN Program
PA	None					None				
RI	None				None	None				
SC										
	Dental	CN	\$1.00		No MN Program	Dental	CN	\$1.00		No MN Program
	Drugs	CN	\$ .50		Per Procedure	Drugs	CN	\$ .50		Per Procedure
	Optometrist	CN	\$1.00			Optometrist	CN	\$1.00		
	Podiatrist	CN	\$1.00			Podiatrist	CN	\$1.00		

\* Reports on 1983 copayments have not yet been received for states with items in parentheses, so these copayments could change.



Exhibit 6-7  
(continued)

FEBRUARY 1982						MARCH 1983				
STATE	SERVICE	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS	SERVICE*	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS
SD	Drugs	CN	\$ .50		No MN Program	Drugs Inpatient Outpatient Physician Dental Dentures (None)	CN CN CN CN CN CN	\$1.00 \$25.00 5¢ \$1.00 \$1.00 \$2.00		Per Stay Per Service Per Service Per Service
TN	None				No MN Program	(None)				No MN Program
TX	None				No MN Program	None				
UT	None					None				
VT	Drugs	CN & MN	\$1.00			Drugs Drugs	CN & MN CN & MN	\$1.00 Variable		\$ .50 on < \$10.99 \$1.00 on > \$11.00
VA	Eyeglasses	CN & MN	\$2.00			Optometrist Clinic Inpatient Outpatient Physician	CN & MN CN & MN MN MN MN	\$1.00 \$1.00 \$30.00 \$2.00 \$1.00		Eye Exams Deductible Nonemergency
WA	Outpatient --Emergency Rm.	MN	\$2.00							
WV	Inpatient Drugs	MN CN & MN	\$85.00 Variable		Each Admission \$ .50 on < \$10.99 \$1.00 on > \$11.00	(Drugs)	CN & MN	Variable		

\* Reports on 1983 copayments have not yet been received for states with items in parentheses, so these copayments could change.

FEBRUARY 1982				MARCH 1983						
STATE	SERVICE	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS	SERVICE*	ELIGIBILITY GROUPS	COPAYMENT AMOUNT	EFFECTIVE DATE	COMMENTS
WI	None					Inpatient Outpatient Aide Durable Medical Equipment Optometrist Chiropractor Dental PT OT Speech, Hearing Language Drugs Dentures Prosthetic Devices --Hearing Aids Eyeglasses Transportation	CN CN CN CN & MN CN CN CN CN & MN CN & MN CN & MN CN & MN CN & MN CN CN CN & MN CN CN & MN CN CN & MN CN CN & MN	\$75/Stay Variable <u>6</u> / \$1.00 \$1.00 Variable <u>7</u> / \$ .50 Variable <u>8</u> / \$ .50 \$ .50 Variable <u>9</u> \$ .50 \$3.00 Variable <u>7</u> / Variable <u>7</u> / Variable <u>10</u> /		In Institutions for Mental Disease Per Procedure Per 15 minutes Per 15 minutes Per Service
WY	None					None				

1/ \$ .50 on \$.01 - \$.8.24; \$1.00 on \$.8.25 - \$23.24; \$2.00 on \$23.25 - \$48.24; \$3.00 on \$48.25+

2/ \$ .50 on \$10.00 or less; \$1.00 on \$11.00 - \$25.00; \$2.00 on \$26.00 - \$50.00; \$3.00 on \$51.00+

3/ Indiana had variable copayments from 8/1/81 - 8/8/81 on the following services: Chiropractor, dental, dentures, drugs, eyeglasses, medical supplies and equipment, optometrist, podiatrist, private duty nursing, prosthetic devices, psychiatric, psychologist, rehabilitative, and physical therapy, occupational therapy and speech/hearing therapy.

4/ \$ .50 on \$10.00 or less; \$1.00 on \$10.01 - \$25.00; \$2.00 on \$25.01 - \$50.00; \$3.00 on \$50.01+.

5/ \$2.00 for per diem of \$275 - \$325; \$3.00 for per diem over \$325.

6/ \$ .50 per hour for independent nursing services; \$ .50 per day for day treatment services.

7/ \$ .50 - \$3.00 per procedure.

8/ \$1.00 - \$3.00

9/ \$ .50 per 15 minutes for some services; \$1.00 per procedure for others.

10/ \$1.00 - \$2.00

\* Reports on 1983 copayments have not yet been received for states with items in parentheses, so these copayments could change.

eligibility to individuals who transferred their property for less than the fair market value in order to become eligible for SSI and/or Medicaid.

OBRA had numerous provisions that related to Medicaid eligibility. Many changes were made by OBRA at the Federal level to immediately reduce the number of AFDC cash assistance recipients nationwide. These AFDC changes of course affected Medicaid in all States as well. OBRA also made several direct changes to Medicaid with regard to eligibility. Most of the Medicaid changes were designed to increase State flexibility with regard to the groups which could be included for Medicaid coverage.

OBRA AFDC-related changes of significance involved the imposition of an income limit at 150 percent of the need standard, a cap on liquid resources to \$1,000 per case, a mandate to all States for monthly income reporting, and several modifications to the treatment of earned income disregards, including standardizing work expenses to \$75 a month, setting a monthly child care maximum at \$160, limiting the use of the \$30 and 1/3 disregard to the first four months of enrollment, and changing the sequence of consideration of the disregards and work expenses in the payment determination process.

The key direct Medicaid changes in OBRA as implemented by Federal regulations included (1) restructuring of the requirements for the medically needy program to allow States to cover only one eligibility group or a combination of groups and to vary the financial eligibility requirements by group; (2) repeal of the requirement that AFDC-related children 18-21 years of age must be covered by Medicaid; (3) restructuring of coverage of "Ribicoff" children, allowing States to set a maximum age for such children at 18 to 20 years; and (4) addition of AFDC optional categorically needy groups to cover pregnant women and participants in subsidized employment.

Two significant eligibility-related changes were included in TEFRA. First, States were extended the option to impose liens on the homes of institutionalized enrollees who are likely to remain in a nursing home. This policy option had been virtually eliminated with the conversion to the SSI program in 1974. However, the rising costs of nursing home care prompted Federal legislators to reinstitute this option to States at least for Medicaid. A second eligibility change included in TEFRA was to extend to States the option to allow certain disabled children to become eligible for Medicaid while living at home, when under past Medicaid law, they would have been eligible only in an institution. These children are often referred to as the "Katie Beckett" children for the young girl

in Iowa whose situation brought this eligibility issue to the forefront. Under previous Medicaid law, parental resources and income were not "deemed" to be available to a disabled child in an institution, but they were regarded as available for a child living at home. TEFRA gave States the option to waive the deeming requirements for disabled children who could be treated at home rather than in an institution if home care would be less expensive and medically and socially appropriate.

#### State Responses to Eligibility Changes

Some of the new eligibility options to States introduced by Federal legislation in the 1980's have produced considerable response at the State level while others have not. Unless otherwise indicated, all of the information reported on State changes come from preliminary 1983 Program Characteristics data by La Jolla.

The ORA change to allow States to prohibit transfer of assets in the 2 years prior to Medicaid application has been adopted by 30-35 States, according to estimates from HCFA's Eligibility Policy Branch. Four States (New Hampshire, North Carolina, North Dakota, and Virginia), according to preliminary 1983 Program Characteristics data, have gone even further and opted for more stringent requirements. Two States will make the retroactive period 3 years. Another two States will extend the period of ineligibility beyond two years if the value of the transferred assets was more than \$12,000.

With regard to OBRA eligibility options, State response has been variable. Of greatest interest, no State so far has adopted a limited medically needy program. Apparently the only States even considering it are States without medically needy programs currently. Thus, it does not appear that this option will be used to reduce program costs.

At least 7 States have set the maximum age for their coverage of Ribicoff children at less than 21 years of age. Thirty-one States have elected to cover pregnant women as an optional AFDC-related categorically needy group, while only 3 States have opted for the coverage of participants in subsidized employment.

Eleven States have responded to the TEFRA option allowing States to cover certain disabled children living at home who would previously have been eligible only in an institution (the so-called "Katie Beckett" children). Interestingly, no States have yet moved to exercise the option of imposing liens on the homes of the institutionalized, according to HCFA's Eligibility Policy Branch. However, program regulations have yet to be released on how such



liens would work. Although many States are reportedly interested in this option, they appear to be reluctant to move until regulations clarify how such a provision might work.

In sum, States seem to have used the greater flexibility in Medicaid eligibility policies afforded them by recent Federal legislation both to contract and expand Medicaid eligibility coverage. Probably the greatest contraction to date has occurred with the ORA transfer of asset options. The expansion has primarily been due to State decisions to cover newly available optional groups.

However, it should be remembered that OBRA mandated that all States implement changes which would reduce the number of AFDC recipients. The reductions in the AFDC caseload presumably reduced Medicaid enrollment and costs as well.

#### 6.7 Family Responsibility

Although there have been no recent Federal changes in Medicaid law which alter the legal responsibilities of the families of Medicaid beneficiaries, there is growing interest at both the Federal and State levels to develop alternative family responsibility requirements which address some of the deficiencies in existing Medicaid program policies. Policymakers recognize that some Medicaid provisions serve as disincentives to families to care for their elderly and disabled kin. For example, it is more difficult to qualify for SSI, and therefore Medicaid, if you are living in the household of another. Second, it is easier to qualify for Medicaid as a nursing home resident than as a non-institutionalized applicant. The income levels for institutional care are higher than those used for applicants living at home. This eligibility provision, while designed to assist persons without other recourse to receive nursing home care, also serves as an incentive to some families to institutionalize their disabled or elderly kin, when non-institutional care alternatives are not available. Third, the deeming of spouses' and parents' incomes is generally less restrictive if the beneficiary is being cared for in an institution. In non-209(b) States, Medicaid cannot deem the income of spouses or parents of institutionalized applicants beyond the first month of institutionalization.

Given these disincentives to family care inherent within Medicaid policy, there is interest at both the Federal and State levels to develop alternative family responsibility policies. A variety of alternatives are being considered. Most have the objective of increasing incentives to families of persons at risk of nursing home placement not to institutionalize their impaired relatives, but to seek alternative modes of care in non-institutional settings. The policies are designed either to

create a financial disincentive to institutionalize (the stick approach) or a positive financial incentive to provide family care (the carrot approach).

Policies using the "stick" approach propose to impose greater financial responsibility on the adult children (and/or parents) of institutionalized Medicaid recipients. In February 1983, HCFA issued a clarification which indicated that State laws of general applicability requiring adult family members to support adult relatives do not violate Medicaid statutes (42 CFR 435.602 and 436.602) which required States to consider only the income and resources of parents and spouses of Medicaid applicants in determining eligibility (HCFA State Medicaid Manual, 1983). The purpose of the clarification was to allow States the flexibility of imposing family responsibility requirements on the relatives of institutionalized Medicaid recipients, should they so choose, as long as such requirements were made under a State statute of general applicability.

While this clarification received a strong negative reaction from the public media and from advocacy groups, several States have expressed interest in this policy option primarily as a means to deter upper income families from abrogating financial responsibility for their elderly kin. As part of this study, USR&E monitored States' responses to HCFA's clarification through phone contacts with States which were known to be considering family responsibility legislation. States surveyed included New York, Georgia, Virginia, Wisconsin, Delaware and Idaho. While legislation proposing broadened family responsibility laws have been submitted in all these States, in only one State -- Idaho -- has the legislation been approved and implemented. Given the political sensitivity of family responsibility programs, many States have chosen to draw upon Idaho's experience with its program before moving ahead with their own programs.

HB 28, passed by the Idaho State legislature early in 1983, requires adult children and parents of institutionalized Medicaid recipients to be assessed for a portion of the Medicaid payment amount. The legislation designated the Idaho Department of Health and Welfare as the agency responsible for developing specific regulations and for administering the program. To address public reaction to the program, the Department decided to conduct four public hearings on proposed regulations. Draft regulations were drawn up which set forth a number of options concerning:

- the deeming of income of spouses of responsible relatives;
- the amount of responsible relatives' income considered available; and
- the monthly assessment amount for various levels of available income and various family sizes.

After input was obtained at the public hearings, the Department issued final regulations and the program became effective on October 10, 1983. In the final regulations, assessments generally do not begin until total annual income reaches at least three times the poverty level. Assessments are established at 4% of adjusted annual income, after deductions. For example, a family of four earning \$30,000 per year, with an estimated adjusted income of \$20,700, would be required to contribute \$69 per month for the cost of a relative's nursing home care.

Idaho, along with three other States -- Oregon, Iowa and Arizona -- is also experimenting with the "carrot" approach by providing tax incentives to families of Medicaid beneficiaries who contribute financially to the care of their elderly kin. Each State's tax incentive program is designed differently in terms of who is eligible to take the credit, the amount of expenses which can be deducted, and the eligibility requirements of the care receiver. For example, Oregon provides a tax credit against expenses incurred by a family member of any elderly person 60 years of age or older. Iowa allows a larger deduction, up to \$5,000 of incurred expenses, but the care receiver must be unable to live independently and be otherwise eligible for public assistance. Arizona, recognizing that a relatively small proportion of its elderly population have children who also live in the State, extends its tax benefit to any informal caregiver, related or unrelated, to the care receiver.

All of these tax incentive programs have only been recently enacted, and there is no available information on the impact of tax incentives on increasing the level of informal care provided by families. Further, participation in these tax incentive programs to date has not been widespread, since public awareness of the availability of the tax credit takes time to develop. However, HCFA has funded a research grant with the Center for Health and Social Services Research to conduct a three-year study of the impact of tax incentives on increasing the level of care provided by informal care givers and on reducing the demand for publicly-provided long-term care services. Information emerging from this study will be useful in ascertaining the relative costs and benefits of the tax incentive approach and in learning how to target tax incentives most effectively.

#### 6.8 Future Evaluation of Medicaid Policy Issues

The HCFA Office of Research and Demonstrations has recently initiated the sequel to the Short-Term Evaluation study: a three-year evaluation effort to assess Medicaid program changes resulting from ORA, OBRA, and TEFRA legislation. This effort, the Medicaid Program Evaluation, began on September 30, 1983, and will culminate on September 30, 1986, with evaluation findings on selected policy issues. The Medicaid Program Evaluation focuses on most of the same policy issues originally selected in the Evaluation



Options for Medicaid report, and addressed in this Short-Term Evaluation report. The topics to be covered by the long-term study include:

- 1) Home and Community-Based Waiver Program. An evaluation effort to assess whether home and community-based service coverage can indeed reduce Medicaid expenditures by diverting persons from more expensive long-term care services.
- 2) Financial Incentives for Family Care. A policy analysis of alternative family incentive options being tried by States, to develop recommendations on Medicaid program changes which would enhance incentives for family care.
- 3) Inpatient Hospital Reimbursement. A major study of the impacts of new inpatient hospital reimbursement methodologies, with a primary focus on the California Selective Provider Contracting Program.
- 4) Freedom-of-Choice Waivers. An assessment of how limitations on freedom-of-choice provisions have affected Medicaid program costs, as well as access to and quality of care provided to beneficiaries.
- 5) Eligibility. A comprehensive analysis of how recent Medicaid, AFDC and SSI program changes have affected Medicaid enrollment and expenditures.
- 6) Cost-Sharing. A quantitative analysis of the effect of cost-sharing requirements on reducing inappropriate utilization of Medicaid services, as well as the possible untoward effects of cost-sharing requirements on program access.
- 7) Federal Financial Participation. A study of Federal program savings achieved by reductions in Federal matching funds, and State responses to these cutbacks.
- 8) Omnibus Reconciliation Act of 1983. A study to monitor even more recent legislative changes in the Medicaid program, and the potential impacts of such changes.
- 9) Synthesis. A study which will prepare an annual interpretation, summary, and synthesis of evaluation results emerging from the eight studies listed above.



The Medicaid Program Evaluation is being conducted through three separate contracts with private research firms. The results of the evaluation will be used by HCFA and other Medicaid policymakers to guide future legislative and policy changes.<sup>47</sup>

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<sup>47</sup>For further information on the status of the Medicaid Program Evaluation, contact the project officer, Gerald Adler, at (301) 597-1414 (FTS 997-1414), or write Medicaid Program Evaluation, HCFA Office of Research, Oak Meadows Building, 2C14, 6325 Security Boulevard, Baltimore, Maryland 21207.

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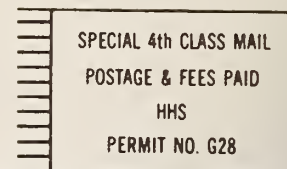
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